DEVON'S HEALTH

IN

1962

The Annual Report of the
County Medical Officer and
Principal School Medical Officer

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COMMITTEES

Health Committee

Chairman: Mrs. J. M. Phillips.
Vice-Chairman: †Rev. J. W. Timms
Chairman of the Council (ex-officio).
Vice-Chairman of the Council (ex-officio).

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Mr. Attenborough	Major Jackson	*Mrs. Perkin
Mr. Daymond	Mr. Lavers	Mrs. Ratcliffe
Mr. Franks	Mr. F. P. Lee	‡Rev. H. S. H. Read
Mr. Graves	Mr. Makeig-Jones	Capt. Roberts
Mr. Hillard	Mr. Moore	Col. Ward

Nominated by the following Bodies

Devon Branch, British Red Cross Society—Lt. Gen. Sir T. Thompson.

Devon Branch, St. John Ambulance Association—§Major T. W. Gracey.

Devon and Exeter Local Dental Association—Mr. G. Pendlebury.

Devon and Exeter Local Medical Committee—
Dr. R. M. S. McConaghey, Dr. G. C. C. MacVicker

Devon and Exeter Pharmaceutical Committee—Mr. T. C. Neville Booth.

Executive Council for Devon and Exeter—Mr A. D. J. Harvey

Women's Voluntary Service for Civil Defence—
Mrs. A. Makeig-Jones.

§Chairman of Ambulance, †Appointments & General Purposes, ‡Adult Health, ||Child Health, *Nursing Sub-Committees.

Water and Sanitation Committee

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Vice-Chairman of the Council (ex-officio).

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Mr. Andrew	Mr. Currey	Mr. Pickard
Mr. Burner	Earl of Devon	Mr. Prowse
Brig. Cameron-Webb	Lt. Col. Journeaux	Mr. F. J. Richards
Mr. Carter	Mr. Makeig-Jones	Flt.-Lt. Symondson

Additional Members

Mr. D. C. Philip Mr. R. R. Willing

School Health Service Sub-Committee of the Education Committee

Chairman: Col. Ward.

Vice-Chairman: Mrs. Hiley.

Chairman and Vice-Chairman of the Council (*ex-officio*).

Chairman and Vice-Chairman of the Education Committee (*ex-officio*).

†Mr. F. U. Crook	Mrs. Perkin	Mr. Short
†Mr. F. P. Lee	Mr. Pridham	Mr. Shapland
†Mrs. Owen	Mrs. Ratcliffe	Mr. Vinnicombe

Additional Members

Mrs. F. Hiley	Dr. Vanstone	Prof. S. H. Watkins
Miss Ragg		

Medical Department,

Ivybank,

45, St. David's Hill,

Exeter.

July, 1963

To the Chairman, Aldermen and
Members of the Devon County Council.

Mr. Chairman, My Lords,
Ladies and Gentlemen,

I have the honour to present my Annual Report for the year 1962.

The publication of the Hospital Plan and the request to Local Authorities for a ten-year forecast of their complementary plans were the outstanding events of the year. As can be imagined any attempt to evolve a blue-print for the services for the next ten years calls for much thought and much consultation with other interested parties, but the task was accomplished in time and the plan adopted by the County Council in October. It would perhaps be as well again to stress that our main emphasis was on prevention. There is also to be increased emphasis on community care which will entail future developments in the nursing, home help and health visiting services, the mental welfare service and in workshops and hostels for the mentally subnormal and mentally ill. Much time was spent by the staff of the Department during the year on this task, and our thanks must be accorded to the Treasurer's Department for all the help and co-operation that was so readily extended.

Hollacombe Workshop was officially opened by Lord Stonham in October. Situated as it is on a magnificent site overlooking Torbay, this purpose-built workshop is a boon to those who use the services. It is too a fruitful example of the co-operation that exists between the voluntary body and the statutory services. The County Council in this instance erected the building, while the Torbay Society for the Mentally Handicapped subscribed heavily to its equipment.

Earlier in the year a new purpose-built clinic at Plymstock also came into operation and forms an excellent base for the services in this expanding district.

This year also saw the first of our courses for trainee General Practitioners which was planned in co-operation with the Local Executive Council. Trainees spent a week with us, mainly in the field, studying the extent and scope of the Local Authority Services, and the exchange of opinion at the end of the course was of mutual advantage. The course was not confined to the medical services and we are grateful to Mr. Speed of the Welfare Department and Mr. Brill of the Children's Department for their participation. It is hoped to make such courses a yearly feature of the work, as a better understanding of one another's function will lead to the smoother working of the Health Service.

Your attention is also invited to the section on health visiting in the body of the report, tracing as it does the changing function of the health visitor in meeting the changing trends in medicine. Health Visitors are now working in closer co-operation with the General Practitioners, and it is hoped to extend the advantages of attachment as described by Dr. Quinnell as soon as more health visitors are available.

We are sensible of the great support that we have had from the various voluntary organisations in the county, and also of the help and co-operation that we receive from the Chief Officers of the County Council. The department is again indebted to the Chairman and Members of the Health Committee for their continued support and understanding.

I have the honour to be,

Your obedient Servant,

W. J. DOYLE,
County Medical Officer and
Principal School Medical Officer.

PUBLIC HEALTH SERVICES

The Minister of Health, both when introducing his 10-year programme for the hospitals and in inviting local health authorities to draw up their own 10-year plans, stressed that our first priority must be " preventive measures to forestall illness and disability " with, as a close second, provision of adequate care at home or in the community "where illness or disability nevertheless occurs." These latter personal care services are dealt with later in this report.

Promotion of health and prevention of disease involves:—

(i) a knowledge of the state of health of the community, of the factors prejudicial to health and of the changing patterns of disease,

(ii) devising and putting into effect appropriate preventive measures.

The State of Health

Traditionally our assessment of health has rested on mortality figures, and in particular infant mortality as being a more sensitive index of adverse social factors. However, the pattern of mortality is changing, serious infectious diseases are under control, and many important disabling illnesses such as rheumatism and mental disorder cripple rather than kill. Mortality figures are thus becoming of less value and we should in future seek additional " barometers of health ": we may also need to make supplementary studies of needs to help plan certain of our preventive and community care services.

We do not yet know the cause of many diseases, and research is essential if we are to prevent certain of them. Some can be controlled through measures applied even before the cause is known. A classical example of this was cholera, which virtually disappeared with the provision of pure water supplies long before the cholera germ was discovered. Today we have the knowledge—the association with cigarette smoking—which should enable us to prevent thousands of deaths from lung cancer before the exact causation has been worked out. Similarly we may well have halved the amount of dental decay before we learn exactly how fluoride helps to strengthen teeth.

Prevention

Prevention has to be tackled in two main ways. Firstly we can control adverse environmental factors without necessarily needing co-operation from every individual in the community. Bovine tuberculosis has now been virtually eradicated by attestation of cattle and pasteurisation of milk: this was achieved by farmers, veterinary surgeons and others with the public largely unaware of the effort. Typhoid and cholera are kept at bay only by the constant vigilance of Water Engineers and others who make sure water supplies are adequately chlorinated; no responsibility falls on the individual citizen for safeguarding himself and indeed only an occasional Zermatt awakens him to an awareness of its importance.

With the second group the problem has to be tackled through individuals. Diptheria and poliomyelitis have been controlled by immunisation of a substantial proportion of our children, and this has involved persuading mothers to let their children be given this protection. It is far more difficult to persuade adults to change their habits, as we know from the smoking problem. It is in such fields that planned, persistent, patient health education is so vitally important.

Deaths

7,954 deaths were recorded during the year, the main causes being summarised in the table below and a detailed breakdown being given in Appendix XVI

	1962
Causes of Death:	
Tuberculosis	26
Other infectious diseases	26
Cancer and other malignant diseases	1,429
Vascular lesions of nervous system	1,315
Diseases of heart and circulatory system	3,207
Diseases of respiratory system (excluding tuberculosis)	738
Diseases of stomach and digestive system	85
Diseases of genito-urinary system	108
Maternal deaths	2
Accident, suicide, etc.	320
All other causes	698
TOTAL DEATHS	7,954

Deaths from tuberculosis showed a further fall from 40 to 26, all except 2 being in people over 45 years of age. Deaths from cancer again rose from 1,344 to 1,429—but the now expected increase for cancer of the lung was more marked for women than men. Other notable increases included vascular lesions of the nervous system in women over 75, and one does not like to see an increase of 23 in accidental deaths (excluding road accidents).

Infectious Diseases

The following cases of infectious diseases were notified to District Medical Officers of Health during the year.

Measles	2,664	Tuberculosis	156
Whooping Cough	68	Typhoid or paratyphoid	2
Diphtheria	—	Dysentery	419
Poliomyelitis	—	Food Poisoning	19
Scarlet Fever	99	Ophthalmia Neonatorum	3
Erysipelas	22	Puerperal Pyrexia	11
Pneumonia	127	*Syphilis	6
Meningitis	1	*Gonorrhoea	49
		*Other Conditions	300

*—Venereal diseases are not notifiable, but figures are given for cases treated at the special centres for the first time during the year.

Of the notifiable infectious diseases, diphtheria and poliomyelitis are now fortunately rare and notification of others such as measles, whooping cough, scarlet fever and pneumonia are of little practical use from a preventive point of view. The time and money spent might be better used on wider epidemiological surveys.

As usual, tuberculosis is dealt with separately.

Vaccination and Immunisation

During the year oral poliomyelitis vaccine became available, and in the interest of uniformity the national schedule for immunisation procedure recommended by the Ministry of Health was adopted. Oral vaccine was issued as from February and the first few batches of this vaccine were kept in a frozen state and issued in insulated containers to outside staff and General Practitioners in the county. The Ministry of Health however, introduced a new stabilised vaccine in July which could be kept in an ordinary domestic refrigerator and this simplified matters as regards distribution.

Dr. Archer reports:—

During the year morning sessions specifically for immunisation were started in two centres, Exmouth and Pinhoe. The arrangement has worked well. For convenience in conducting the Clinic, appointments are given in batches according to the immunising procedure intended. Mothers find the waiting time much reduced and we believe there is an important improvement in the Child Welfare sessions which were being swamped and rushed by immunisation: one can now listen to the problems that mothers want to discuss in detail without the nagging certainty that there are several other mothers waiting "just for immunisation" with an anxious eye on the clock because of shopping to be done or the young school child to be met. It has been a great help in completing tetanus immunisation in school children to have these regular morning sessions purely for immunising.

Dr. Budding reports:—

Acceptances for B.C.G. Vaccinations were round about 80 per cent again. The acceptance rate for primary prophylaxis of infants remains high, but there is still a falling off in the acceptance rate for booster doses in older children, which is to be deprecated, particularly with regard to Tetanus; however to counter-balance this it is pleasing to report a greater number of parents accepting primary immunisation against Tetanus (together with Diphtheria booster) at the time of entry to school.

Smallpox Vaccination

The figures for 1962 showed a very considerable increase in vaccination against smallpox. This was due to the incidence of cases in South Wales and other parts of the country at the end of 1961 and continuing well into the first quarter of 1962. The figure for primary vaccination of children increased by 50% and re-vaccination showed a phenomenal increase.

Smallpox

	Primary Vaccinations			*Re-vaccinations*
	under 1 year	*over 1 year*	*Total*	
Undertaken by M.Os.	440	2,642	3,082	628
Undertaken by G.Ps.	1,399	26,778	28,177	41,633
Total	1,839	29,420	31,259	42,261

Diphtheria

The figures for immunisation against diphtheria are again almost identical with the preceding year although every effort was made to increase the number of children immunised by propaganda and visits by Health Visitors. It is gratifying to know that there was no case of diphtheria in the county during this period.

Diphtheria (including combined vaccine)

	Primary Courses			
	Infants and Pre-School Children	*School Children*	*Total*	*"Booster" Injections*
Undertaken by M.Os.	2,202	774	2,976	2,642
Undertaken by G.Ps.	4,192	333	4,525	1,224
Total	6,394	1,107	7,501	3,866

Whooping Cough

A very slight improvement in the number of children protected against whooping cough is shown.

Whooping Cough (including combined vaccine)

	Infants and Pre-School Children	*School Children*	*Total*	*"Booster" Injections*
Undertaken by M.Os.	1,903	202	2,105	66
Undertaken by G.Ps.	4,124	277	4,401	835
Total	6,027	479	6,506	901

Tetanus

The figures for tetanus immunisation continue to increase; this is particularly so in the school children where the increase was threefold.

Tetanus (including combined)

	Infants and Pre-School Children	*School Children*	*Total*
M.Os. (Primary).	2,190	1,583	3,773
G.Ps. (Primary)	4,166	1,997	6,163
Total	6,356	3,580	9,936

B.C.G.

The number of children Heaf Tested prior to B.C.G. shows a slight increase during this year. The percentage of positive reactors showed a 4% decrease and the number of children negative a slight increase of 2%.

	School Children 13+	*Students Attending Further Education Establishments*
No. of children for whom parental consent received.	5,675	66
No. tuberculin tested (Heaf test 2 mm. puncture).	5,581	46
No. positive	878	18
No. negative	4,576	28
No. given freeze-dried B.C.G. vaccine	4,474	28

Poliomyelitis

The introduction of oral poliomyelitis vaccine in February worked very smoothly. The figures given in the following table show a decrease in children receiving fourth injections and this is due to the fact that oral vaccine only requires 3 doses. Very few General Practitioners are using vaccine for injections but the Ministry are still issuing it when required.

Dr. Archer comments:

" The advent of oral poliomyelitis vaccine has been a blessing, particularly as immunisation against poliomyelitis comes at the time when babies both sense very quickly any maternal anxiety and begin to recall settings having an unpleasant association. They seem to enjoy their vaccine given in rosehip syrup and the atmosphere suggests a babies' "elevenses" cafe rather than an immunising Clinic."

SALK. Poliomyelitis 1st January-31st December, 1962

Undertaken by	1—15 *years*	16—25 *years*	26—40 *years*	*Others*	*Total*
M.Os.	523	1,729	366	543	3,161
G.Ps.	420	2,039	993	2,567	6,019

	Oral (Reinforcing) After 2 Salk Injections	*Oral (Reinforcing) After 3 Salk Injections*	*Total*
A.C.M.O's	1,730	1,527	3,257
G.P.'s	5,422	1,187	6,609

Poliomyelitis Oral (3 doses)

	1—15 years	16—25 years	26 40 years	Others	Total
A.C.M.O's	1,021	421	205	216	1,863
G.P's	1,396	451	356	560	2,763

Tuberculosis

In 1962 new notifications totalled 156—115 pulmonary and 41 non-pulmonary—with the following age/sex distribution.

Age	*Pulmonary*		*Non-Pulmonary*		*All forms T.B.*		
	Males	*Females*	*Males*	*Females*	*Males*	*Females*	*Total*
Under 5	0	2	0	0	0	2	2
5—14	3	3	1	2	4	5	9
15—24	6	8	0	2	6	10	16
25—34	7	13	5	5	12	18	30
35—44	11	5	3	5	14	10	24
45—54	16	4	1	4	17	8	25
55—64	12	4	3	5	15	9	24
65+	10	11	1	3	11	14	25
Unknown	0	0	0	1	0	1	1
Total	65	50	14	27	79	77	156

These figures, like last year's, illustrate the fact that amongst men the older age groups are more susceptible, whilst for women the peak incidence is in the child-bearing age.

Occupation

Details of occupations of the notified cases are given in Table I (appendix). The classification has been modified to follow the changes made by the Registrar General in his socio-economic groupings in

connection with the 1961 Census. As before, we have added a few special groups of housewives, retired persons, etc., rather than grouping according to husbands' or previous occupation. These figures will be analysed further as soon as the Census report for Devon is available.

How detected.

Once again more pulmonary cases were picked up by direct referral from General Practitioner to chest clinic than in any other way, although this year the proportion coming from public mass X-ray sessions and the Heaf testing scheme increased.

How Picked Up	*Pulmonary*	*Non-Pulmonary*	*Total*
G.P. to Chest Clinic	34	9	43
G.P. to Mass X-ray	4	—	4
Contacts of known cases	4	—	4
Hospitals	28	17	45
Public Sessions Mass X-ray	13	—	13
T.B. Tests	9	—	9
No information available	23	15	38

Source of Infection

The difficulty of pin-pointing a source of infection in many cases is again demonstrated by the following figures:—

Presumed Source of Infection	*Notifications*		
	Pulmonary	*Non-Pulmonary*	*Total*
Milk	—	—	—
Family	12	1	13
Friends	6	—	6
Work	2	—	2
Unknown	65	22	87

Site of Disease

115 cases were pulmonary. Of the 41 non-pulmonary there were 18 cases of T.B. glands, 5 abdominal, 6 genito-urinary system, 6 bones or joints and 6 others.

Clinical Assessment

The assessment of severity made by the Chest Physicians for the purpose of returns to the Ministry of Health is also given in Appendix Table II.

Bacteriology

Bacteriological investigation was not undertaken, or results are not yet available, in 62 cases. In 29 cases negative reports were obtained, and of the positives, 27 were by smear, 27 by culture, 2 after bronchial lavage and 9 cases were from other specimens.

Contacts

Contact tracing had been completed in 123 cases by the end of the year and results of this work were as follows:—

Contacts examined		*No. of cases T.B. found*
Household — Spouse	53	1
Household — Children	103	4
Household — Other adults in same house	58	6
Total household:	214	11
Neighbours, friends or relatives not living in household	214	1
Contacts at work, in school or elsewhere	57	—

Trends

Study of annual figures such as these are of interest, but as they are relatively small one cannot deduce changes much from year to year. From time to time therefore it is helpful to examine trends over longer periods, and it is planned to do this again next year.

Case Finding

Mass Radiography. Dr. Templeton reports on the activities of the Mass Radiography Unit as follows-:

" The current policy of selective Mass Radiography continued throughout the County of Devon during 1962. The number of cases of pulmonary tuberculosis requiring treatment showed a slight increase (.7 per 1,000 in 1961: .82 per 1,000 in 1962). The greatest yield was from the Devon County tuberculin testing scheme for school entrants when the positive reactors and their close contacts were X-rayed by us. Five new cases of active pulmonary tuberculosis were found. We will continue to offer facilities for X-raying school and hospital staffs on a yearly basis, as we still pick up above the average number of new cases in these groups.

Routine visits to towns and villages for general public service are arranged at approximately three-year intervals, and all general practitioners are encouraged to send along to these sessions all patients with chest symptoms and those he feels to be specially susceptible to tuberculosis. I would like to see a greater number of people attending for miniature film X-ray on such recommendation by their family doctors, so that we can completely eradicate the remaining small pool of infectors in the county."

Details of the work and cases found appear in Appendix Table III.

Dr. Templeton has also kindly provided a detailed analysis of those passing through the Mass X-ray Unit, split down into age and sex. Although the yield of cases is approximately the same for men (.8 per 1,000) and women (.9 per 1,000) there are very striking differences between the age groups. In the 15—35 group the yield for women is 6 times that for men whereas the position is completely reversed in the 45—60 age group—yielding about 4 times as many cases as women per 1,000 examined. This emphasises the point made in connection with the ages of the newly notified cases, i.e. that our case-finding efforts should be concentrated on women of child-bearing age and on men over the age of 45.

Heaf Testing

We agreed to assist the Ministry of Education in an investigation into the rates of natural tuberculin conversion at various ages in school children, with the purpose of observing whether a pattern emerges showing the most susceptible ages. The Tiverton area was chosen for a pilot scheme as a previous study was done here and it was thought comparisons might be interesting.

The routine Heaf testing scheme has been extended to include all the 12 year old children in Secondary Modern and Grammar Schools, so that in effect all children between 5 and 12 years of age will be tested. The investigation will continue over a five year period so it will be some time before any conclusions can be drawn.

During this school year the numbers tested were almost indentical with those in 1960/61. The number of children who show a positive reaction on school entry has again fallen sharply but the number of children who have converted from negative to positive has shown an increase. 9 cases of tuberculosis were found during this year as opposed to 4 during the previous year. It is proposed to continue annual Heaf Testing of primary school children for the time being.

Report on Heaf Testing Scheme from 1st September, 1961 to 31st August, 1962.

	Primary	*Conversions*	*Total*
Found Positive	119	374	493
Positive Children X-rayed	95	372	467
Contacts X-rayed (adults)	155	512	667
(children)	30	75	105
Cases Picked up—			
Positive Children	1	1	2
Adult Contacts	2	4	6
Child Contacts	—	1	1
No. of schools tested			354
No. of Children Tested (all ages)			34,850

Interpretation of Heaf Test results

Dr. Solomon had some doubts about the *Significance of Grade I Heaf Positive* results and planned a study with the co-operation of Dr. W. Lloyd (Chest Physician). Dr. Solomon reports:—

"At the time of inspection the 111 Grade I Positives were sub-divided into 69 Grade I (*a*) (4 to 6 papules) and 42 Grade I (*b*) (6 definite papules almost touching). Dr. Lloyd did Mantoux Tests (1/100) on the 69 Grade I (*a*) Positives and found that only 28 were Mantoux Positive while 41 were Mantoux Negative." As a result of these preliminary findings a more extensive survey by several School Medical Officers has been planned for next year.

Treatment

Chest Clinics. The work of the four Chest Clinics is summarised in the table below:—

	Torquay	*B'stple*	*Exeter*	*Plymouth*	*Total*
Patients on Register 1.1.62	1,123	703	1,268	344	3,438
New Notifications					
(a) respiratory	36	27	43	23	129
(b) non-respiratory	11	8	9	7	35
Deaths	17	12	31	7	67
Patients on Register 31.12.62	1,106	540	1,268	355	3,269
First examination of suspects	1,037	100	1,090	1,197	3,424
Cases of T.B. found	45	2	52	17	116
Contacts examined	318	559	463	463	1,803
Cases of T.B. found	0	2	3	2	7
Contacts vaccinated with B.C.G.	144	76	207	155	582

Dr. Adkins (East Devon) and Dr. Wyndham Lloyd (Torquay) both stress the changing nature of their work and indeed of tuberculosis as a disease. Dr. Mellor (South-West Devon) comments that of the 355 on his Register he had only one persistently positive case remaining at home at the end of the year. He also refers to the higher incidence of non-pulmonary tuberculosis and mentions that 3 of the 7 cases notified in his area were in glands of the neck in elderly adults.

Hospital Treatment

The changing patern of chest disease is again emphasised by the fact that of the patients admitted to Hawkmoor Hospital during the year less than 20% were suffering from tuberculosis.

Dr. Midgely continues:—" For the first time since these records were compiled the number of patients suffering from cancer equals the number suffering from tuberculosis, there being 217 of each. If the present trend continues cancer will in future be the disease which will take numerical pride of place for both admissions and deaths. Emphysema and bronchitis accounted for 120. The proportion of elderly patients continues to increase, 22.7% of those admitted were more than 65 years old. Some of these patients also have other conditions usually associated with old age, and they make very heavy nursing. The number of deaths was 84 of whom 57 died from cancer."

ENVIRONMENTAL HEALTH

District Medical Officers of Health

The prime responsibility for keeping a watchful eye on the environment lies with the District Medical Officer of Health. It is essential that he should be specially qualified and be experienced in this branch of medicine, and also be free to devote an adequate amount of time to preventive work—hence the policy of the Ministry of Health for full time Medical Officers of Health.

Mention was made last year that five authorities in the Bideford area made a " combined " appointment of Medical Officer of Health, and we welcomed Dr. Mervyn Thomas to this. Discussions were also held this year with the Tiverton and Crediton Councils, who decided to postpone consideration of a " mixed " appointment for the Crediton area until the retirment of the present Medical Officer of Health to the Tiverton Borough and Rural District Council

Food & Milk

Food hygiene is supervised by District Medical Officers of Health and the Public Health Inspectors but, with the exception of Torquay, sampling of foods under the Food & Drugs Act, 1955 is undertaken by County Sampling Officers.

The County Public Health Inspector submits the following report for 1962:—

During the year, 2,850 formal and informal samples were taken by the four full-time and two part-time Sampling Officers employed in the Department. 967 (123 milk and 844 other commodities) were submitted to the Public Analyst and the remaining 1,883 (all milks) were examined by the Gerber Test in the Laboratory attached to the Department.

The samples submitted to the Public Analyst represented a wide range of foodstuffs and medicines including milks, ice cream, sausages, spirits and various proprietary medicines and drugs.

The Public Analyst reported that of the 967 samples 63 were either adulterated or gave rise to some other irregularity. 35 of the 63 samples were of milk and 14 contained added water. As a result, 8 vendors were prosecuted and a warning letter was sent in 7 other cases. The other 21 samples of milk were ones in which the non-fatty solids and/or butter fat was below the normally accepted

figure, but investigation in each case showed that the milk was being sold in the same condition as it came from the cow and that no offence under the Food & Drugs Act was being committed.

The remaining 28 samples other than milk reported on by the Public Analyst included a wholemeal loaf containing pieces of cotton material, a meat pie containing flakes of iron rust, chocolate containing a piece of iron wire, sponge cakes with a growth of mould, pasties contaminated with a growth of mould and a sausage roll contaminated with a growth of mould. There were prosecutions in these 6 instances and warning letters were sent in 5 other cases.

The Sampling Officers take their samples with very considerable care and selectivity. Apart from the help given in this Department, they are assisted and advised in their choice of samples by consultation with the Public Analyst and by a close study of the reports issued by the Public Analysts of other Counties and publicised accounts of legal action taken by other Food & Drugs Authorities.

Milk

The hygienic production of milk on the farm is the responsibility of officers of the Ministry of Agriculture, Fisheries and Food.

The Divisional Officer of the Ministry informs me that at the end of December, 1962, there were 8,579 registered milk producers, 7,076 of whom held T.T. licences; this latter figure should continue to increase at a steady rate.

During the year, 440,000 cows were tuberculin tested in the County. Of these there were 516 reactors and 274 showed lesions of tuberculosis. This is a dramatic improvement upon the position in pre-war days, when over one-third of all cattle reacted to the Tuberculin Test. I also understand that a good start has been made in the scheme for calf vaccination against brucellosis. It is to be hoped that there will soon be 100% acceptance since unless the disease can be eradicated, or all milk is pasteurised, there will be a continuing risk to consumers—quite apart from economic effects on a farm where infection occurs.

Biological Examination of Milk for the Presence of Tuberculosis

During the year a total of 666 samples was submitted, special attention being paid to milk to be sold unpasteurised. There were no positive results.

The figures for the preceding 10 years are as follows.—

Year	*No. of Samples*	*Positive Results*
1952	781	11
1953	475	3
1954	1028	12
1955	1941	5
1956	959	nil
1957	831	4
1958	1107	2
1959	905	2
1960	679	nil
1961	627	nil

Milk and Dairies Regulations, 1949.

The County Council issued licences to the 6 Pasteurising Plant operators remaining in the County and a very carefull watch is kept on both the Plants and the processed milk. This involves regular inspections and samples are submitted for laboratory examination at very frequent intervals. Additional checks on the quality of the processed milk are afforded by the routine sampling of milk supplied to the schools in the County. A very large proportion of school milk is derived from these Plants.

The Milk (Special Designation) Regulations, 1960

These Regulations, which came into force on January 1st, 1961, gave to the County Council the duty of licensing all dealers in designated milk—hitherto the province of the District Councils.

This has meant the inspection and general approval of the premises and milk handling facilities of 795 dealers, and a comprehensive sampling programme is now in being.

During the year the following samples were submitted.—

Pasteurised	*Total*	*No. Failing Phosphatase Test*
	1268	nil
Tuberculin Tested	*Total*	*No. Failing Methylene Blue Test*
	548	33
Sterilised	*Total*	*No. Failing Turbidity Test*
	24	nil

Milk in Schools Scheme

The tendering and three-year contract system of supplying the schools with milk which commenced in 1955 has worked with great success as far as this Department in concerned. Of the 444 schools of all types (the difference between this figure and 466 as shown in 1961 is accounted for by closures and amalgamation), 416 take Pasteurised milk derived from 5 of the Pasteurising establishments. This has enabled effective supervision of the supply of be maintained, but as it also means that any breakdown of control or supervision could place a large proportion of the County's population at risk, constant vigilance is more important than ever.

551 samples of Pasteurised milk were submitted for examination and all passed the Phosphatase Test. 83 samples of Tuberculin Tested milk were also examined by the Methylene Blue Test.

Water Supplies

The three Water Boards—the North Devon, the South Devon and the East Devon Water Boards—have all been active during the year, and all have substantial schemes, either in course of construction or awaiting the consent of the Minister of Housing and Local Government. This progress is emphasised by the increasing amount of precept which each Board makes on the County Council.

Comparative figures are as follows:—

	1960/61 *Actual Cost*	1961/62 *Actual cost*	1962/63 *Probable Cost*
North Devon Water Board:	£216,597	£248,620	£277,750
South Devon Water Board:	£155,856	£152,375	£159,775
East Devon Water Board:	£77,037	£87,726	£89,500

The North Devon Water Board now covers an area of 1,621 square miles; 905 miles of mains have been laid and the average quantity of water supplied is between 6 and 7 million gallons per day. The total expenditure incurred by the Board up to March, 1962, was £5,193,860. The works at Belstone, to treat water from the Taw Marsh scheme, were under construction this year.

The South Devon Water Board has a statutory area of supply amounting to 240 square miles. 295 miles of mains have been laid and the total amount of water supplied during 1962 was 654 million gallons, including 120 million gallons supplied to Paignton Urban District Council from the new Ranne plant, near Totnes. The total capital expenditure at the end of March, 1962, was £2,586,657.

The East Devon Water Board covers an area of 204 square miles; 157 miles of mains have been laid and the output during 1962 was 522 million gallons. The total Capital expenditure was £1,253,243.

The Minister of Housing and Local Government had not, by the end of the year, made any decisions regarding regrouping of water undertakings in South or in East Devon.

During the year grants under the Rural Water Supplies Act were agreed to in principle on the following schemes:—

Local Authority	*Parishes or Area Affected*	*Estimated cost*
Newton Abbot R.D.	Bishopsteignton	£1,820
Newton Abbot R.D.	Ipplepen	£9,577
Newton Abbot R.D.	Kingsteignton	£1,550
Newton Abbot R.D.	Widecombe-in-the-Moor	£5,985
South Molton B.C.	Clapworthy Mill	£3,234
Torquay B.C.	West Ogwell	£15,731

Fluoridation

The report "The Conduct of the Fluoridation Studies in the United Kingdom and the results achieved after Five Years" was published during the year. This showed, as had been expected from experience in other countries, and from our knowledge of areas in this country where the water supply already contained 1 p.p.m. of fluoride or more, there was up to 60% less dental decay. The Water & Sanitation Committee decided that water undertakings in the county should be asked to add fluoride where necessary and, in October, 1962, the County Council resolved:—

" That the water undertakers in the county be approached with a view to sufficient flouride being added to public water supplies to raise the fluoride content to one part per million."

Later in the year the Minister of Health made it clear that where fluoridation is necessary it should be undertaken as part of the preventive services under the National Health Service Act, and consequently it will fall to the Health Committee to carry the Council's resolution into effect.

Sewerage and Sewage Disposal

The following schemes submitted to the County Council for financial grants were examined by the County Public Health Inspector and recommendations in each case were made to the Water and Sanitation Committee:—

Local Authority	*Parishes or Areas affected*	*Estimated Cost* £
Axminster R.D.	Dalwood	24,000
Axminster R.D.	Membury and Rock	21,000
Bideford R.D.	Higher Clovelly	1,304
Buckfastleigh U.D.	Extension to sewage works	6,950
Buckfastleigh U.D.	Sewers at Buckfast	11,050
Crediton	Fordton and Lords Meadow	296,500
Crediton R.D.	Newton St. Cyres	82,500
Honiton R.D.	Talaton	20,400
Kingsbridge R.D.	Galmpton and Outer Hope Cove	49,900
Newton Abbot R.D.	East Ogwell (revised scheme)	47,527
Newton Abbot R.D.	Heathfield	6,500
Okehampton R.D.	Spreyton	20,006
Paignton U.D.	Sharkham Point Outfall	12,000
Plympton R.D.	Elburton	27,000
Plympton R.D.	Plympton Sewerage	24,000
Plympton R.D.	Yealmpton (Stage 2)	78,000
Salcombe U.D.	Revised Scheme	74,292
St. Thomas R.D.	Tedburn St. Mary (revised scheme)	44,550
Seaton U.D.	Town Sewage Disposal Scheme	197,326
South Molton R.D.	Kingsnympton (revised scheme)	11,836
Tavistock U.D.	Town Scheme	154,000
Tiverton R.D.	Ashill	20,000
Tiverton R.D.	Butterleigh	11,520
Tiverton R.D.	Hemyock	65,000
Tiverton R.D.	Nomansland	9,850
Tiverton R.D.	Pennymoor	11,300
Torrington R.D.	Extensions to Sewage Works	53,700
Torrington R.D.	Ashreigney	24,000
Totnes R.D.	Capton (Dittisham)	5,640
Totnes R.D.	Harbertonford	897

HEALTH EDUCATION

This is the first complete year of activity since the appointment of a Health Education Officer.

Health Visitors, District Nurses and other members of the staff have conducted group discussions, talks and displays in various parts of the County, in a similar manner to that outlined in last year's report. In addition to meeting individual requests for help with various aspects of this work, Miss Davies has been engaged in discussion with the Domestic Science Organisers in preparation for a Domestic Science Teachers Conference to be held early in 1963 with the theme " A New Look at Health Education in Secondary Schools " and has helped to plan and carry through several projects including the following:—

SPECIAL PROJECTS

DISPLAYS & EXHIBITS

May—Devon County Agricultural Show. " Food Health " (school-children and adolescents).

August—Exeter Flower Show (in conjunction with Exeter City Health Dept.) " Safety in the Garden for the Under Fives."

November—County Hall. " Work from the Handicapped Workshops."

IN-SERVICE TRAINING

April—Social Workers in Mental Health. 2 one-day Courses at Barnstaple and Torquay " Communcation " and " Uses of Aids."

April—Study Day for Health Visitors/ District Nurses/ Midwives. Health Education visual aids and materials.

August and November Sessions for staff at Plymstock Clinic, Dawlish Clinic, Paignton Clinic, on 16 mm. cine/sound projection and film care.

Loan and Distribution of Visual Aids

31 films hired

Use of film strips, sound F.Ss, flannel graph and displays—193 times.

own films used 159 times

Smoke and Health

Much of the time and resources of the Section have been devoted to the anti-smoking campaign.

In March, the Minister of Health drew the attention of Local Health and Education Authorities to the report of the Royal College of Physicians on "Smoking and Health." He recommended the giving of more education to the public and the need to emphasise the hazards of smoking, with particular stress on preventing young people and school children acquiring the habit.

The Health and Education Committees agreed to co-operate and also that efforts should be concentrated on youngsters before they acquired the habit.

Meetings were then held with the Chief Education Officer and teacher representatives from County Primary, Secondary Modern, and Grammar Schools, and Technical and Teacher Training Colleges to discuss the framework of a campaign. Much useful advice was received and the objectives were recognised as being the need:—

1. To appeal to adults particularly parents and teachers, both to set an example and to help young people to think for themselves rather than be influenced by advertising or other pressures.

2. To draw Youth's attention to the fact that smoking was not necessarily being "grown up" and that it was a habit rather than a status symbol as advertisers try to infer.

3. To make available correct, up-to-date information about the dangers of smoking, and stressing advantages of not smoking rather than using the weapon of fear of disease.

A successful campaign would involve many groups of people, but it was recognised that so far as the children were concerned the teachers had the greatest influence. It was acknowledged too, that such a campaign must be a long term project which would require a fresh approach and new or revised materials from time to time.

To help in the campaign it was also suggested that certain special teaching aids be made available to the schools and that we should prepare pamphlets more likely to appeal to teenagers. The School Health Sub-Committee agreed to the proposals and to meet the cost.

The remainder of the year was spent in the detailed work of planning design and preparation, ready to launch the campaign early in 1963.

Supplies of a letter to all parents (printed in our Oakleigh Workshop at Barnstaple) were to be distributed through the schools. This read:—

Dear Parents,

As you know, smoking is the main known cause of lung cancer and it is also a factor in other illnesses, particularly chronic bronchitis. It is important that young people should never acquire the habit, as some of us know from experience how difficult it is to give up smoking.

This letter is an invitation to you to join us in making children aware of the hazards. A campaign is starting in the schools so that every child will know the facts, and special pamphlets will be available to teenagers.

As the subject is bound to come up at home, I hope you will talk to your children about it and encourage them to think for themselves. You can help them to see that to be " grown up " is not necessarily to follow the crowd and pressures of advertising, but rather to use their own judgement in making a decision.

Yours sincerely,

W. J. Doyle.

The Chief Education Officer and I prepared a joint letter to all Heads describing the plans and seeking their co-operation. Heads were also to be sent copies of the report " Smoking and Health " for Secondary School libraries, supplies of the special pamphlets (on the theme " Only a Square Smokes ") together with information concerning all teaching aids available. Specimens of the first two of the following specially prepared aids will also be sent to all secondary schools.

Teaching Aids No. 1 — *Flannelgraph*—depicting changing patterns of mortality generally (1921-1961), and highlighting that lung cancer is now taking the place of tuberculosis as the most important preventable " killer " disease.

No. 2. — *Wall Chart*—showing (*a*) increase in deaths from lung cancer from 1921 onwards.

(*b*) Smoking habits of men and women from 1900 onwards.

(*c*) By superimposing one on the other, the association between the two.

No. 3. — *Flannelgraph* (for use more with adult groups) illustrating the report by Dr. Dolland and Professor Bradford Hill in 1956

" Lung Cancer and other causes of death in relation to smoking "—proving the association between tobacco consumption (especially as cigarettes) and deaths from lung cancer.

A considerable amount of publicity material, posters and information was also distributed to District Councils and County Libraries, General Practitioners and Clinics.

The date of commencement of the campaign in schools was scheduled for January, 1963 and steps were taken to obtain publicity on sound radio, television and the Press.

The final segment to the campaign plan was to select an appropriate slogan to appear for three months on the reverse side of all County Council envelopes.

" Smoking . . . . . Harms Health!
Let's Prevent Youngsters Starting."

PERSONAL HEALTH SERVICES

MATERNAL HEALTH AND NURSING

Maternity Services

In the County 7,694 live births were notified during the year (as adjusted for transfers in and out).

Domiciliary	2,670
Institutional	5,024
Total	7,694

For each of the past four years there has been a steady rise in the total number of births. The increase has once again been more in the number of hospital than in the domiciliary confinements. A considerable number of mothers are still discharged from hospital, especially the consultant units, before the tenth day. Next year it is planned to try a system of early discharges from two of the more hard-pressed normal maternity units. It is hoped that this will make fuller use of existing accommodation as suggested by the Cranbrook Committee Report on maternal care. Inevitably the work of the domiciliary midwives in these two areas will be considerably increased, but the results of early discharge of selected mothers will be watched with interest.

The work of the midwives is summarised in the table below:—

Midwifery

Domiciliary deliveries attended	2,600
Nursing care of mothers discharged from Hospital before 10th day	1,010
Attendances at G.P. Ante-Natal Clinics	2,553
Attendances at County Council Ante-Natal Clinics	1,646
No. of cases in which Gas and Air was administered	2,306
No. of cases in which Trilene was administered	53
No. of cases in which Pethidine was administered	1,541
Total number of Midwifery and Ante-Natal visits to home deliveries	72,108
Total number of Ante-Natal visits to Hospital booked patients	12,995

Ante-Natal Clinics

There are now 30 clinics giving courses on health education, exercise and relaxation. About 30 per cent of the expectant mothers in the County attend these classes, most of these expecting their first baby. 2,102 women made a total of 9,053 attendances.

Dental Care of Expectant and Nursing Mothers and Young Children

The following tables give details of patients and treatment given under the Maternity and Child Welfare Scheme. Of the 254 mothers seen 226 required treatment and of the 564 infants examined 378 also required treatment.

A. Number Provided with Dental Care.

	Expectant and Nursing Mothers	*Pre-School Children*
Examined	254	564
Needing Treatment	226	378
Treated	234	362
Made dentally fit	127	206

B. Forms of Treatment Provided

	Expectant and Nursing Mothers	*Pre-School Children*
Scaling and Gum Treatment	134	34
Fillings	280	400
Ag. $N.O^3$ Treatment	3	91
Crowns or Inlays	1	—
Extractions	348	294
General Anaesthetics	38	95
Dentures		
Full upper or lower	46	—
Partial Upper or lower	21	—
Radiographs	23	2

Family Planning

	New Cases	*Continuation Cases*
Exeter Women's Welfare	112	683
Plymouth District		
St. Budeaux	18	70
Plympton	55	—
Plymouth City	126	535
Torbay—		
Paignton	7	20
Dartmouth	45	118
Launceston	32	44

A new branch of the Family Planning Association was opened at Plympton midway through the year.

Grants continue to be paid to all the branches with the exception of Paignton and Plympton, where clinic premises are used without charge in lieu of a grant.

Full use continued to be made of the facilities available.

Care of Unmarried Mothers and Their Children

Despite an increased number of illegitimate babies there is no significant increase in the actual proportion of illegitimate births. Except during the war years, there has been an almost constant illegitimate birth rate of around five per cent. In the past there was apparently much less attention devoted to the needs of the illegitimate child, and this may well explain the present general impression that there is an increasing incidence.

A small increase in the total nevertheless causes a considerable increase in the amount of help needed from the social agencies and this is especially so in the case of the very young mother.

The Exeter Diocesan Council for Moral Welfare was concerned with 384 cases during the year. 144 were referred by the County Council. The number of cases admitted to Mother and Baby Homes increased by 13 to 72, 24 of these going to St. Nicholas House, where five places are reserved for Devon girls.

Infant Welfare Services

The vital statistics for 1962, set out in the form requested by the Minister of Health are:—

Live Births:	Number	7,786
	Rate per 1,000 population	14.51
Illegitimate live births per cent of total live births		6.05
Stillbirths:	Number	119
	Rate per 1,000 total live and still births	15.05
Total live and stillbirths		7,905
Infant Deaths (deaths under 1 year)		127
Infant Mortality Rates:		
Total infant deaths per 1,000 total live births		16.31
Legitimate infant deaths (116) per 1,000 legitimate live births		15.86
Illegitimate infants deaths (11) per 1,000 illegitimate live births		23.35
Neo-natal Mortality Rate (deaths under 4 weeks (90) per 1,000 total live births)		11.56
Early Neo-Natal Mortality Rate (deaths under 1 week (74) per 1,000 total live births)		9.50
Perinatal Mortality Rate (stillbirths and deaths under 1 week combined (193) per 1,000 total live and stillbirths)		24.41
Maternal Mortality (including abortion)		
Number of Deaths		2
Rate per 1,000 total live and still births		25

Stillbirths

106 stillbirths were notified in the County during the year (as adjusted for transfers in and out).

Domiciliary	8 including	3 premature stillbirths
Institutional	98 including	41 premature stillbirths
Totals	106	44

It is pleasing to be able to report that the number of stillbirths is again down, but prematurity remains a closely associated factor with the incidence of stillbirths.

Mortality Rates	*England and Wales*	*Devon*
Still births (per 1,000 live and stillbirths)	18.1	15.05
Perinatal (per 1,000 live and stillbirths)	32.2 (1961)	24.41
Neonatal (per 1,000 live births)	15.5 (1961)	11.56
Infant Mortality (per 1,000 live births)	21.4	16.31

Perinatal Loss

The perinatal loss continues to show a satisfactory downward trend, and with a total of 19.3 maintains a rate of 24.41 markedly below that for England and Wales.

Premature Births

Premature live births totalled 395, a rate of 5.1 per cent. 345 of these survived the first 28 days of life. The survival rate has not been quite so good as in 1961, but in that year Devon had a perinatal loss over the period when most premature babies die, markedly below the national average.

Table V (appendix) shows the birth weight, place of birth and number of premature babies surviving in each group at the end of 28 days. It is noteworthy that the 67 premature babies born and nursed entirely at home all survived 28 days and that 15 of these weighed between 3 lbs. 4 ozs. and 4 lbs. 15 ozs.

Child Welfare Centres

There were 81 Child Welfare Centres providing services during the year. 12,869 children were brought by mothers a total of 94,381 times. Mothers continue to make very full use of the facilities, but the number of children over 2 years of age attending is less than one would like. These three years between infancy and school days are important ones and if the staffing position permitted it

would be desirable to develop special appointment sessions for the child over two so as to obviate this gap. In one area these special sessions have been held with great success, and the medical officer concerned is most enthusiastic, but finds himself with insufficient time to meet the growing demand.

Number of children attending	*Year of Birth*	*Number of attendances made*
4,248	1962	61,487
3,725	1961	15,917
4,896	1957-1960	16,977
12,869		94,381

Voluntary workers continue to give most valuable help on the clerical and social sides of the Child Welfare Centres and their assistance is greatly appreciated. It is worthy of record that there are quite a number who have regularly devoted their time to this work for more than a quarter of a century.

Distribution of Welfare Foods

Once again there is a reduction in the amount of welfare foods issued, and this is especially marked with the vitamin supplements. The distribution of cod liver oil is less than one bottle for each child born, and orange juice averages only just over two bottles for each potential user. Fortunately children are obtaining vitamins from other sources such as the fortified baby foods and the earlier introduction of mixed feeding. One would particularly wish that more mothers availed themselves of the vitamin tablets during pregnancy although maternal health is generally far better than thirty years ago.

I should particularly like to take this opportunity of thanking the many voluntary workers, including members of the W.V.S., who undertake the actual work of distribution, and to the officials of other departments of the County Council who act as Area Depot Officers, and to all other Area Depot Officers.

An exchange of views at the Child Welfare Centre

A Home visit by the Health Visitor

Photo: Copyright, Sean Hickey, Torquay.

HEALTH VISITING SERVICE

The centenary of health visiting was celebrated in 1962. We have come a long way from the first home visits made by the ladies of the " Manchester and Salford Sanitary Reform Association," a courageous band of voluntary visitors who distributed health tracts in the homes and left carbolic powder and carbolic soap as practical tools with which to implement their teaching. Their work was difficult but they were motivated by a genuine concern for the poor living conditions of people in these Boroughs and a desire to improve the health of the children.

In 1892 Florence Nightingale became interested in this work and with the help of Dr. De'Ath, M.O.H. and Public Vaccinator, a training course was started. This was specially arranged for the particular needs of a rural community. Battersea College of Technology began health visitor courses in 1909. Training regulations were issued in 1919 and revised in 1925 and 1949. Over the years the pattern of training has kept pace with the changing needs of the community, and in addition health visitors attend a post-graduate course every five years to enable them to refresh their ideas.

In the early days of the school health service, which began in the period 1902—1907, the school nurses were fully occupied carrying out treatments of skin conditions, verminous bodies and heads, discharging ears and infected eyes, many of which were associated with malnutrition. There was no free medical service to cover such treatment. To-day in many parts of the country these conditions are rarely seen, due in large part to improved standards of nutrition, better housing and to the home visiting and health teaching over the years.

The number of Child Welfare Centres and health visitors showed a marked increase during the first world war, partly attributable to a more general concern over the health of the nation and partly to the Notification of Births Act in 1915, which, of course, meant that numbers and whereabouts of infants were known and a check could be kept on their health. Until 1918, home visiting in Devon was carried out by district nurses employed by the Devon Nursing Association. In 1917 the then County Medical Officer reported that " the high infant morality rate urgently calls for the provision of Child Welfare Centres and health visitors." In 1918 the first health visitors were appointed, but only 9 were obtainable out of an establishment of 15.

The work of the health visitor was not always appreciated and on one occasion her knock at the door was answered by a jug of cold water being poured over her from an upstairs window! Resentment such as this was probably engendered by the fact that

many of the earliest health visitors had been trained as sanitary inspectors and some householders felt that they only came to see if the house was clean.

In the years between the two wars much of the energy of the health visitor and school nurse was spent in wrestling with poverty and malnutrition. Hours were spent in securing help from charitable sources to enable families to have medical treatment. Many of these families living below subsistence level were either too proud, or the conditions under which they could obtain free medical care were too difficult for them to accept it. In the midst of widespread poverty problem families did not stand out from their neighbours as they do to-day.

But the social picture has changed since the second world war. Rationing of food during the war provided a more balanced diet than many people had had before and this improved general nutrition of children. The issue of vitamin supplements to expectant mothers and children under five also played an important part. It was during this period that the major immunisation campaigns got under way to combat infectious diseases: that against Diptheria started in 1947, and this aspect of the health visitors' work has continued in relation to an increasing number of diseases as knowledge has advanced. This is a good example of the changing pattern of the health visitors' work, immunisation at this stage taking over the emphasis which previously had lain with conditions arising out of poverty.

Before 1940 the middle and professional classes were rarely visited, but during the war when their husbands were often away from home, they became most appreciative of the help of the health visitor. They often made out lists of questions to ask her when she called and also telephoned in emergency. This practice has continued and in 1948 the duties of the health visitor were widened to include the whole family. This extended horizon reflected the growing appreciation of the family as a unit, improvement in the physical standards of the children enabling a clearer understanding of the importance of mental health both as a factor in any physical illness and in the interactions of members of the family. The health visitor is expected to notice, and deal with, the earliest signs of instability in family relationships as well as to give support in the after-care of any person who has been suffering from mental illness.

Over the years the scope of preventative work has increased tremendously, and the health visitor is always in the front line to deal with practical aspects of this; hence she encourages mothers to have their children immunised and in the schools makes sure the children have regular vision and hearing tests, hygiene inspections, and medical inspections at which she assists the doctor in particular by providing any relevant social history. The annual Heaf testing

of children, a procedure by which it is possible to trace unknown cases of T.B. in the community, involves a great deal of work because of the need to track down contacts of positive reactors and persuade them to attend for X-ray.

The work relating to the care of the aged has gradually increased. Elderly people are referred by hospital almoners, general practitioners, relations, neighbours and some times by the Clergy.

The health visitor visits patients discharged from hospital when requested. The majority of requests relate to children and old people, but some concern the need for investigation of home circumstances of severely handicapped adults. The success of such contacts depends upon good liaison between hospital almoners and health visitors and in Devon we are fortunate in enjoying this.

The health visitors assist in the practical training of social science students from Exeter University; student nurses from a number of hospitals in the County, as well as student health visitors from Bristol University, London University and Battersea College of Technology. The students usually accompany the health visitors for periods varying from a half day to two weeks.

Liaison with General Practitioners

This year a special effort has been made to improve the liaison between health visitors and family doctor. The extent of this naturally varies with the area and facilities available, both in terms of premises and of staff: in many areas it amounts simply to a good interchange of information, in others a health visitor may assist a General Practitioner at a Child Welfare Clinic held in his surgery or a General Practitioner conducting a clinic in one of our Child Welfare Centres. In one area each group practice is visited twice weekly by a health visitor and she passes on information to her colleagues, the other health visitors still being free to visit the surgery to discuss a particular problem. In another we have been able to place a health visitor within a group practice of four General Practitioners. She has found it of benefit as a means of finding those needing advice and help, and more interesting to be one of a team especially as she had previously worked on a single district. The patients like the arrangement, and she enjoys a better relationship with the local hospital which is a General Practitioner unit. Because of the pressure of work to be done she has had to be relieved of most of the duties of a school nurse, but she does follow up any school child about whom the doctors are concerned. The doctors have found her work to be of great value to the practice and they have never misused her services. This has been a very interesting experiment and it is most unfortunate that the number of health visitors is inadequate to repeat this at present—apart from the fact that there are approximately six General Practitioners to each health visitor in Devon.

Dr. G. A. F. Quinnell, a senior partner of the practice to which Miss Howard has been attached, has kindly provided his own impressions of the experiment.

"Miss Howard, a qualified nurse and health visitor, was attached to the partnership of Drs. Quinnell, Kelly, Clayton-Payne and Butterfield in November, 1961. Previously she had been a separate health visitor in the town for about 15 months. We were asked to regard this attachment as a trial and therefore did our best to discover how we could best obtain mutual value from the association.

Early discussion revealed that Miss Howard had felt starved of professional contact and in many ways isolated. The first effort was therefore directed to enabling her to use the central surgery of the firm as a place where she could meet doctors and other medical and social professional people. She was given the use of a large and cheerful room, with facilities for seeing people by appointment, and lock-up arrangements for private papers. She made use of the secretarial staff for patient contacts.

The lines of development which showed themselves to be desirable were the linking up of the County Social Services for young and old and the General Practitioner Health Services. Miss Howard continued to attend the County Clinic and to do many duties relating to the School Medical Services separately from this general practice, but all the immunisation records from the County pass through her hands and she was able to develop considerable collaboration between the County Medical Services and General Practice.

In order to make her aware of the possibilities of mutual development between General Practitioner and a social worker she was encouraged to sit in on some surgeries, followed by discussion of the various social problems which showed themselves. Similarly she attended and assisted with an immunisation clinic run by one of the partners, and the ante-natal consultations. Through these various contacts she was able to make the social services of the County more fully available to individual patients and families.

To detail the results of Miss Howard's association with this medical firm, the various sections in which she has become interested can now be taken in order.

Expectant mothers attend the partners at set times. Some of us make use of the District Midwives to act as nurse attendants so that the ante-natal problems are mutually known; and Miss Howard attends as she requires to on these occasions, when she has proved invaluable in a multitude of ways, most especially when there have been ante-natal family difficulties.

Infants are an especial charge in any town and here, because of the good ante-natal contact, the infant care that Miss Howard can give is first class. She has come to know the mother, the doctor and the infant and therefore has been able to maintain an above average proportion of breast feeding, and later an almost hundred per cent immunisation and vaccination. It is obvious too that her

knowledge of family peculiarities are useful both for the doctors' use and for hospitals to which they may go. There is also a two-way contact between the family doctor service and the County Infant Welfare Clinic and the County Medical Officer.

Children's welfare is an extension of infant care. Again the access which Miss Howard has had to doctors' records and letters enables her to give a much fuller service to individual children; and special grades of children, such as diabetics, epileptics, spastics and asthmatics are enabled to have better care. County preventative services, such as Heaf Tests, are readily available through Miss Howard.

Old people are a great problem in these coastal towns: up to her attachment to us Miss Howard says that she had little idea of the extent of the social problem presented by the very old, and except for occasional referrals by doctor or W.V.S. she had no means of contacting this group of people. She now seeks for and receives details of any old people likely to be in need of the County Social Services. This is a developing pattern of considerable importance, which has been hastened by the severity of this winter.

Family problems and especially marriage and teenage difficulties seem to present a useful area of health visitor and general practitioner co-operation. In fact this side of the contact is developing less than most others. There seems to be a certain amount of diffidence about married people discussing marital problems with an unmarried relatively young health visitor.

School leavers have presented some medico-social problems. We have tried to make contact between Miss Howard and the Ministry of Labour to help these young people. The development of this side of the attachment is going to be a slow one, which we will learn by experience of individual cases. The real problems are relatively infrequent, but usually exceedingly difficult.

Miss Howard keeps contact with the General Practitioner Hospital, which we use.

For the future there would seem to be an opportunity to develop this attachment towards the follow-up of groups of diseases, such as epileptics, to ensure continuity of treatment, and possibly some simple research projects, again especially the follow-up of specified diseases.

To conclude, this attachment of a health visitor to a General Practice partnership, working from a central surgery in a town with a General Practitioner Hospital, has been a considerable success. Miss Howard has become so much a necessary adjunct to the effective running of this general practice that we all feel that if we now lost this health visitor attachment, the service available to the patients would be very much poorer."

The health visitor works as a member of a team with other social workers dealing with the needs of special families. Meetings are held to discuss the needs of these families and to prevent duplication of visiting wherever possible.

This is only an outline of the work of the health visitor but it is interesting to trace the changing pattern and in doing so one can see the necessity for a health visitor to be flexible both in her methods of approach and her attitudes: general standards of life and behaviour vary from age to age and from one community to another, and through it all the health visitor must see each person as an individual and yet as a member of the family and of the larger community outside. No easy task, but one which is well worth while.

A summary of the work undertaken by the health visitors during 1962 is given below.:—

Type of Visit	*No. of Visits*
Infants under 1 year	48,661
Children 1—2 years	18,789
Children 2—5 years	34,767
Age Groups 5—15 years	10,363
Age Groups 15—65 years	14,821
Expectant Mothers	4,576
Tuberculosis	1,707
Aged	6,812
Hospital After-Care	478
Home Help Service	2,227
Under Children's Act	1,133
All Others	466
Attendances at Centres, Clinics, etc.	8,910
Households Visited	27,214
" No Access " Visits	17,371
Health Education	
Group Talks to Mothers	515
Talks given in Schools	148
All Other Talks	182

HOME NURSING

Midwifery

There has been little change in the number of domiciliary cases undertaken although there has been a small increase in the past year. The work associated with the early discharge of mothers from hospitals and maternity units has increased considerably, as many more mothers are coming home from hospital within a few days of delivery. The staffing position has improved during the year and every district is now adequately staffed.

Health education and relaxation classes appear to be of great assistance in reducing the length of labour, but some mothers find difficulty in attending the classes and arrangements are made for this advice to be given by the midwives in their own homes. An extension of these classes is desirable and it is hoped to increase sessions gradually.

Home Nursing

This field of service continues to expand and more elderly people are being nursed at home. Great benefit is derived from the use of nursing aids, lifting poles and hoists, and these help considerably with the rehabilitation—particularly of stroke cases. There has been an improvement in the recruiting of staff and every vacancy for home nursing has been filled. For some years now we have been taking student nurses from the local hospitals and introducing them to some of the aspects of Public Health services, and now some of these students have applied to us for appointments to the home nursing service. This is a very satisfactory arrangement.

There seems to be an increase in the number of cancer patients nursed, and these derive great benefit from the " Day and Night Nursing Service " and the welfare grants supplied through the Marie Curie Memorial Foundation Fund.

On looking into the past history of the midwifery and home nursing fields it would appear that trends are tending to be reversed. In the days of voluntary associations much more concentration was paid to domiciliary midwifery and less attention to the home nursing service. Today this has already been reversed and, looking to the future, we can envisage that more people will be nursed at home, particularly medical and long-term illnesses, and an increasing number of confinements will take place in institutions.

The work of the district nurses is summarised in the following table:—

No. of Medical cases nursed	8,755	involving	212,407	visits
No. of Surgical cases nursed	2,428	,,	47,875	,,
No. of Infectious Diseases cases nursed	8	,,	145	,,
No. of Tuberculosis cases nursed	43	,,	2,908	,,
No. of Maternal Complications nursed	285	,,	1,941	,,
No. of other cases nursed	512	,,	21,917	,,

These figures include 7,735 patients over 65 years of age who received a total of 186,029 visits; 510 children under 5 who received 2,514 visits; and 2,068 patients who each received more than 24 visits in the year, the total number of visits involved to these patients being 142,554.

Registration of Nursing Homes

Three Nursing Homes were re-registered on change of ownership. One home previously registered as an Old People's Home reverted to being a Nursing Home. The certificate of registration of one home was surrendered when the premises were taken over by the Regional Hospital Board. Four other proprietors returned the certificate on retirement or change of usage.

At the end of the year there were 29 registered Nursing Homes, providing 30 maternity beds and 286 medical, convalescent and chronic beds.

Nurses' Act, 1919-1945.

Two applications for renewal of licences to carry on agencies for the supply of nurses under these Acts were received and approved during the year.

HOME HELP SERVICE

During the year demands have continued to increase, and we have seen ample evidence of the growing importance attached to the work of the Home Help as an invaluable member of the home-care team. The status of the Home Help has undergone a tremendous change, and this is being reflected in the work now undertaken and the type of person being recruited. With the growing awareness of the great benefits it is not surprising that the demand for a good Home Help Service continues to accelerate, and praise is due to all Organisers. Health Visitors and District Nurses engaged in the control of the Service throughout the county, for managing to keep up with the increased demand and changing patterns.

At 31st December, 1962, the W.V.S. were organising the day-to-day running of the Service at:—

AXMINSTER	ILFRACOMBE	SIDMOUTH
BARNSTAPLE (U/R)	IVYBRIDGE	TAVISTOCK
BIDEFORD	KINGSBRIDGE	TEIGNMOUTH
BRIXHAM	PLYMPTON	TIVERTON
DARTMOUTH	PLYMSTOCK	TOTNES (R)
HONITON	SEATON	

Area Organisers are now responsible for the Service at:—

BOVEY TRACEY	NEWTON ABBOT	ST. THOMAS R.D
DAWLISH	URBAN AND	TORQUAY
EXMOUTH	PART RURAL.	BOROUGH
	PAIGNTON	

The Crediton area was covered by the County Organiser, and the remainder by Health Visitor and District Nurses.

At the end of the year 808 Home Helps were employed, all part-time and during the year 3,282 households received help through this Service. Details of these cases are set out in the table below.

	Maternity	*T.B.*	*Chronic sick incl. aged*	*Others*	*Totals*
1. W.V.S.	114	5	975	214	1,308
2. D.C.C. Organisers	163	—	1,105	224	1,492
H.V's. and D.N's.	80	2	324	76	482
Total County Staff	243	2	1,429	300	1,974
TOTAL of 1 & 2	357	7	2,404	514	3,282
Increase or decrease on 1961 figure	+7	—3	+334	+74	+412

The overall increase of 412 cases in 1962 is approximately 14½ per cent, and in the group concerned with the care of the aged the increase is about 17 per cent.

The daily case-load at 31st December, 1962, was 1,966, of which 1,653 were in connection with the care of the aged—approximately 85%. This percentage has remained steady over the past four years and tends to show that we may expect progressive increases in the years ahead. Due to the increased birth rate we may expect to have to deal with more home confinements in future and more cases requiring home care following short-term hospitalisation. There is a greater demand for pre-natal care, especially in cases of toxaemia of pregnancy.

The care of the aged in their own homes is of course the major problem to be dealt with, The majority are long-term cases during the lifetime of the patient which, with advancing years, present a variety of problems to Organisers and Home Helps, and it is true to say that the Service has developed a " type " of Help who has a real concern for the care of old people. A great number of them render services outside the scope of their normal duties, for which they do not receive, or expect, any payment. A sense of vocation is being developed in the Service and we have been fortunate in our recruitment and in retaining the services of such women. In spite of the increasing demand and case-loads, Organisers, in general, have been able to enlist Home Helps of the type we need throughout the county, and there has been no time lag in meeting the needs of new cases.

Once again my thanks go to all the W.V.S. Organisers and their colleagues for all their work on behalf of the Service during the year. Many are coping with very heavy case-loads and are giving a great deal of time to the organisation of the Service in their areas. My thanks also to the officers of the National Assistance Board for their continued invaluable help and co-operation. In some instances they not only bring the cases to us but also find the Home Helps! Many cases are dealt with outside the Service, where it is more economical and practicable to do so. The Education Welfare Officers do excellent work in collecting the majority of the accounts in connection with the Service. The expansion of the Service inevitably means more collections for them to make, and their understanding and tolerance in dealing with all sorts and conditions of people, often under trying circumstances, is appreciated. Finally, thanks are due to the hundreds of Home Helps throughout the county who carry out the work of caring for the aged, with so much kindness and consideration.

THE PSYCHIATRIC SOCIAL SERVICE FOR ADULTS

New patients during the year were referred as follows:—

	1962
By General Practitioners	539
Hospitals, on discharge	291
Hospital Out-Patient's Dept.	276
By Police and Courts	47
By other sources	251
	1,404

THE MENTALLY ILL

Community Care:

	1962	1961
Patients receiving community care from Social Workers.	1,286	1,144
Visits to patients by Social Workers.	11,271	9,474

During the year, the field staff of 18 Social Workers based on eleven area officers were grouped into four general divisions, each of which serves the catchment area of the nearest psychiatric hospital or of the proposed psychiatric units to be attached to the new Barnstaple and Torbay District Hospitals where out-patient clinics are already in existence.

1. East and Central Devon (Exe Vale Hospital)
2. North Devon (Barnstaple Out-Patient Clinic).
3. South Devon (Torquay Out-Patient Clinic).
4. South-West Devon (Moorhaven Hospital).

It is most pleasing to record that two Social Workers were accepted by the National Institute for Social Work Training for their twelve months' full-time Course for experienced officers, and for a further Social Worker to commence a part-time Course at the University of Exeter for the Diploma in Social Administration. This naturally placed, and continues to place, a heavy strain on the remaining staff who, to their credit, have responded magnificiently and have even increased the number of visits paid to patients. It has been possible as well to continue to receive pupils from the Exeter University and the psychiatric hospitals, to the mutual benefit of both Social Worker and pupil.

Some Social Workers have spent a short time within a psychiatric hospital, whilst Nurses have been seconded to our field staff, with a resultant free interchange of useful ideas. Lectures to hospital staff, and talks to voluntary organisations, have continued as part of the health education programme.

Hospital Admissions and Discharges of the Mentally ill

Mental Health Act,1959	*Exe Vale Hospital*	*Moorhaven Hospital*	*Out-County Hospitals*	1962	1961
Informal Patients	1,109	167	3	1,279	1,281
Observation (Sect. 25)	96	12	2	110	107
Treatment (Sect. 26)	8	2	1	11	14
Emergencies (Sect 29)	276	38	8	322	247
Courts (Sect. 60)	3	1	—	4	7
Total Admissions	1,492	220	14	* 1,726	1,656
Total Discharges	1,333	22	—	1,355	1,238

* Of this total 602 were re-admissions, i.e. 34.9%.

Transfers from one hospital to another 4.

Visits by Social Workers in respect of admissions 3,247.

Deaths

While in hospital	201
While in the community	23

Although smaller than in the previous year, a further rise occurred in the total number of admissions due to a larger number of emergencies. Persons re-admitted for further treatment accounted for over one-third of the total admissions, and it is imperative for additional community services to be more readily available to improve this position. In this connection, whilst realising that the need of each patient varies, the following will indicate some of the main ways in which additional help should be forthcoming:—

More social work to prepare the patient for his discharge, and to prepare his home environment to receive him.

Therapeutic Social Clubs to add friendship and restore initiative.

Hostel accommodation as halfway houses into full community life.

Suitable working conditions, including sheltered employment.

THERAPEUTIC SOCIAL CLUBS:

Torquay. This Club, the first to be formed, continued to meet in a Torquay Cafe, and has had a most successful year under the leadership of the Social Workers who have devoted a great deal of time and energy to arranging entertainments, games, outings and sick visits. There are 106 members, with an average weekly attendance of about half this number, although 84 came to the Christmas Dinner.

It has been gratifying to learn from the Social Workers at Exe Vale Hospital of the excellent effects the Club is having on discharged patients. The fact that it meets in the room also used by the Torquay Rotary Club has done much to enhance its prestige.

Barnstaple. On the 8th May, 1962, the Brownlees Social Club commenced in a Church Hall, and the average weekly attendance is 38. A Social Worker organises the club programme and has secured the valuable services of voluntary helpers and transport from the Round Tables of Barnstaple and South Molton, the Soroptomist Club and other voluntary sources, together with a donation from the North Devon Association for the Handicapped. The business houses of Barnstaple were largely responsible for the success of the Christmas Party, and the Youth Council plan to hold one for the Club in the New Year. The Social Workers from Bideford have organised their own area and, with voluntary help from the Rotary Club, W.V.S. and Round Table, bring in a weekly contingent. In 1963 a separate club will probably be commenced for the Torridge area.

Paignton. Although only commencing on the 2nd November, the Paignton Club, which meets at Mayfield, has a membership of 49 and an average attendance of 30.

In the case of all the clubs, the Social Workers are responsible, but each has its own chairman, secretary and treasurer, who are given responsibility, and all the members are encouraged to take an active part in club affairs.

Other members of the department's staff—occupational therapists, workshop and clerical staff, and health visitors—voluntarily help regularly to make the evenings successful.

There is no doubt as to the value of this work in rehabilitating patients discharged from hospital back into the community, and it has been found that many persons previously exhibiting a high and early relapse rate have now settled happily in work and home, and will themselves attribute this change to their evening out in the club's friendly atmosphere where, if needs be, they can readily seek advice from the Social Worker.

REGISTRATION OF MENTAL NURSING HOMES

Five Homes continued to be registered during the year under Part III of the Mental Health Act, 1959, each being visited twice during the year by the Senior Medical Officer and the Senior Social Worker in Mental Health.

There are in total 124 beds at these Nursing Homes and, on the 31st December, 1962, 86 were occupied.

These patients are encouraged to take advantage of the County Council services such as attendance at the Workshop and Therapeutic Social Clubs.

THE MENTALLY SUBNORMAL

Community Care:

During his last six months at a Special School for the Educationally Subnormal, or one of our training schools for the mentally subnormal (Junior Training Centres), each child was assessed as a whole personality, his work potential was considered, and the appropriate arrangements made for his outside employment, admission to an adult workshop, or to receive visits from the occupational therapist, the last named being arranged for those living in areas not served by a workshop.

In all cases the Social Worker in Mental Health provided full community care when the child left school.

	1962
Number of adults placed under community care	72
Number of adolescents placed under community care on leaving school	59
Number considered no longer in need of care	63
Number remaining under care	849
Number of visits	3,864
Remaining under Guardianship	2*
Deaths whilst in the community (all natural causes)	2

The only Devon patient under Guardianship was discharged and is now settled in the community as a worker in a poultry packing factory, and earning £12—£14 per week.

* These patients remain technically under Guardianship of other Local Health Authorities, although visited by Devon staff.

Hospital Admissions and Discharges of the Mentally Subnormal

Mental Health Act, 1959	1962	1961
Admissions:		
Informal	82	65
Observation (Sect. 25)	0	1
Treatment (Sect. 26)	6	3
Emergency (Sect. 29)	0	1
Court Order (Sect. 60)	4	3
Total	92	73
Discharges	*60	78
Hospital transfers	6	5
Deaths in hospital	15	9
Temporary hospital admissions (not exceeding 2 months)	25	41
Visits by social workers in respect of admissions	203	—

* Includes 18 persons technically discharged but remaining resident informally in hospital.

Patients Remaining in Hospital for the Subnormal

	Detained	*Informal*	*Total Detained & Informal*
In hospitals within South West Regional Board area	101	758	859
In hospitals outside the Region	4	17	21
In Special hospitals	30	—	30
TOTAL 1962	135	775	910
TOTAL 1961	152	741	893

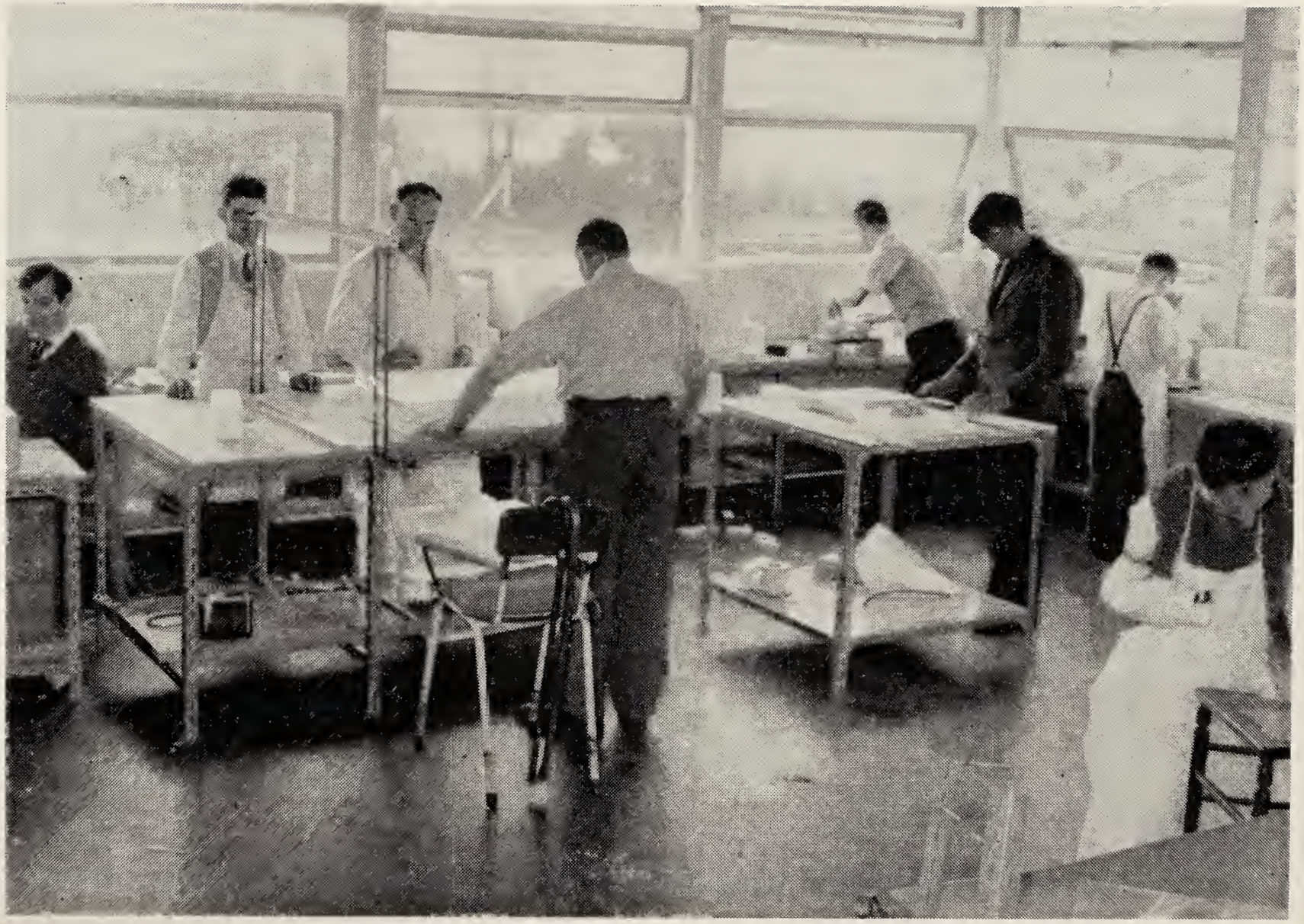
Hospital Waiting List

	Boys	*Girls*	*Men*	*Women*	*Total*
Patients awaiting admission 1962	4	3	9	3	19
Patients awaiting admission 1961	8	6	23	3	40

Although lower than in the previous year, the number of hospital discharges remains at a reasonable level, considering the acute shortage of facilities available within the community.

The waiting list for admission was more than halved, to 19, and of this total only 5 could be considered urgent.

A Workshop at Hollacombe



Dowel Drilling at Hollacombe

WORKSHOPS, REHABILITATION/TRAINING UNITS, OUTWORKERS AND OCCUPATIONAL THERAPY

There are in Devon over 800 adults so handicapped, mentally or physically, as to be incapable at present of normal employment, and who are considered outside of any Ministry of Labour scheme.

The Health Committee aim to provide four large workshops, each with a rehabilitation/training unit (Paignton, Barnstaple, Exmouth and Plympton), and five smaller ones (Axminster, Crediton, Tavistock, Kingsbridge and Newton Abbot), together with an outworker scheme for the homebound, or those living too far away from a workshop. Men and women are referred for workshop training from many sources, including hospital consultants, general practitioners, social workers in mental health, other social workers, occupational therapists, Managers of Employment Exchanges and the National Assistance Boards, Heads of special schools and junior training centres.

Each applicant for admission is now seen by an assessment panel which consists of the senior medical officer, workshop manager, social worker in mental health and occupational therapist, and to which the family doctor, hospital consultant or other social workers involved are invited, or asked to send a report. Priority of admission is thus established, and the workshop staff have some idea of the new worker's capabilities, both socially and in work potential.

The rehabilitation/training units, which are urgently needed, will in due course take the new entrant, and will be staffed by trained persons who will aim at a full assessment and will train each individual in domestic and other similar tasks, the achievement of a work habit and use of tools, etc. Attention will be paid to further education, reading, writing and arithmetic, money values, and in other ways to make the person independent, and eventually fit him to leave the workshop for outside employment and as full a community life as possible. If the person is physically handicapped, training will also take place in the use of aids to daily living, in a specially adapted kitchen and bed-sitting room.

A small start has been made by the occupational therapists in this scheme, but unfortunately there is as yet little accommodation or equipment, and the staff, already stretched to their limits, are forced to give up other work to undertake these duties.

In the workshop proper, work will be provided as follows:—

1. By sub-contract from industry.
2. Products for sale direct to industry, wholesaler or retailer.
3. Contract printing.
4. As outworkers from industry.
5. From contracts obtained through " VELEXE " Products, Ltd., which is a new non-profit-making company which has been set up with the aid of a generous Nuffield Grant to provide work for the workshops of the Exe Vale, Moorhaven and Royal Western Counties Hospitals, Exeter City and Devon County Workshops.

The primary aim of the workshop is to enable as many persons as possible to take their places in outside employment. If this fails, then protected working conditions are provided, with the work being made suitable to the individual's requirements. Eventually it is hoped to make all work purposeful, however simple it may be, because the worker will surely achieve a fuller degree of satisfaction when he realises his usefulness in, and to, the community. A graduated course to full sheltered workshop conditions is planned for the future.

Number of Trainees Attending Adult Workshops

Workshop	*Mentally Ill*	*Mentally Subnormal*	*Physically Handi-capped*	*Total*
Axminster	1	7	2	10
Barnstaple	2	16	12	30
*Exeter	—	6	—	6
Exmouth	4	23	6	33
†Kingsbridge	—	6	—	6
Newton Abbot	2	9	7	18
Paignton (Hollacombe)	8	49	27	84
‡‡Torquay (Barton)	1	3	9	13
Tavistock	—	6	4	10
Total	18	125	67	210

* By arrangement with Exeter City L.H.A.
† In conjunction with the Torbay Society for the Mentally Handicapped
‡‡ In conjunction with the Hospital Management Committee.

Hollacombe Workshops, Paignton

Since November, 1955, The Torbay Society for Mentally Handicapped Children ran a daily Centre for some 40 men and women, who formed the nucleus of the early intake to Hollacombe when this fine purpose-built workshop for 60 adults was commenced in August, 1962. The County Council was responsible for the building, whilst the Society largely equipped and furnished it out of their appeal funds, and will continue to contribute towards this. It stands on approximately one acre of ground overlooking Torbay, and is actively engaged in producing insulating sets for cold-water storage tanks, pipe-lagging shells, insulation boards, ceiling and wall tiles, etc. for the building industry, packaging pieces for electronic and other equipment, cutting and drilling thousands of dowels for a local firm, soft toys, pan-scourers, paper bags, etc. An increasing number of firms are now looking solely to the workshops when they require cheap and efficient packaging of delicate equipment using polystyrene, which is a substance so light as to reduce transport costs, yet highly resistant to damage.

By the end of December, 90 trainees had been enrolled, and the average daily attendance had increased to 84, with 15 persons on the waiting list. This unfortunately means a long wait for many, and

can be disastrous for young school and junior training centre leavers, who need these services and will lose the value of the education and training already received. It is also unfortunate if places cannot be offered to discharged hospital patients who are not ready for full outside employment and who need a period of training under protected conditions if complete rehabilitation is to be achieved.

Oakleigh Workshops, Barnstaple.

The 2-day-a-week Work Centre which operated at the clinic was transferred in August to the old Oakleigh Road premises on completion of new school buildings for the children. By the end of December, 30 trainees were in full-time daily attendance, with a further 17 on the waiting list, all of whom it will not be possible to accommodate until the rehabilitation/training unit is established. This it is planned to do early in the New Year on two days a week at the clinic, under the care of the occupational therapists.

The principal work undertaken at Barnstaple is printing, from the simplest form to pictures in brilliant colour, and to date many contracts have been undertaken, including the production of Christmas cards for a London distributor, and material for the County Council. Art work and original design is undertaken by the Manager, who is an expert in this field. Other activities include woodworking, making of soft toys, rugs and various sewn articles, picture frames, etc.

The North Devon Association for the Handicapped kindly arranged an outing to Minehead, and a Christmas Party for the trainees.

Exmouth Workshop

In June this became the first workshop in Devon to commence full-time operations. Unfortunately it uses hired premises, where facilities are extremely limited, as everything has to be cleared away at the end of each day, to allow the hall to be used for other purposes in the evenings and at week-ends.

Nevertheless, by the end of December, 33 trainees were in attendance and were engaged in manufacturing articles in polystyrene (as at Hollacombe), assembly of electric sewing-machine plugs and leads, and using electric sewing-machines for various purposes. The trainees are instructed in dress-making and domestic subjects, and cook their midday meal.

Smaller Part-time Workshops

A 1-day-a-week Workshop was commenced in Axminster on the 24th January, 1962, and the weekly groups continued to meet in Newton Abbot and Tavistock, although the latter was suspended for several weeks owing to the ill-health of the teacher-in-charge, and was eventually re-opened in more suitable premises.

Barton (Torquay) continued on two afternoons per week, in association with the occupational therapist attached to the Torbay Hospital, and Kingsbridge continued to be run by the Torbay Mencap Society twice weekly.

In an effort to make the best use of available staff, Bideford, Heavitree and Sidmouth Centres were closed and the work done in each was transferred to one of the other workshops.

Domiciliary Occupational Therapy:

Number of Patients receiving Domiciliary Occupational Therapy

Devon	*Mentally Ill*	*Mentally Sub-normal*	*Tuber-culous*	*Physically Handi-capped*	*Total Patients*	*Visits* 1962	1961
North	8	25	19	68	120	895	1790
South	25	11	17	49	102	893	1186
East	13	27	35	65	140	2390	3595
West	5	18	4	24	51	649	1199
Total	51	81	75	206	413	4827	7770

This service was particularly hard hit during the year when out of a staff of eight for reasons of sickness, marriage and a resignation, for much of the year the work was valiantly attempted by the remaining four members who worked long hours with already inflated caseloads still more heavily loaded. This came at a particularly unfortunate time with the occupational therapists committed to workshop groups and eager to develop the rehabilitation/training units. The service, however, was maintained to three County Welfare Homes and the Steps Cross School for physically handicapped children.

These circumstances left much to be desired, although happily by the end of the year all the vacancies had been filled. One therapist, however, does not commence duties until the New Year and there naturally remains a heavy backlog of work which will prevent an efficient service being restored immediately. In view of the staffing position and lack of suitable work the outworker scheme was commenced for only four persons.

Leisure Clubs:

The Torbay Leisure Club met on two evenings per week, once at Hollacombe and once at the Torquay Swimming Baths where for two hours exclusive use has been granted. Members of the Workshop staff run the Club and are ably supported by friends and other employees of the County Council. Nearly all the Workshop trainees attend and are joined in the activities by other handicapped persons for whom outside employment has been obtained.

The newly formed Exmouth Leisure Club meets weekly and is also run for the trainees by the Workshop staff.

A small club for women is run in Barnstaple by the Devon & Exeter Association for Mental Health but will be merged with the Workshop Leisure Club when this has been organised.

THE CARE OF TUBERCULOUS PATIENTS

The provision of extra nourishment, in the form of free milk, continued, and 37 (65 in 1961) patients benefited in this way. Nine open-air shelters were still in use, and 75 patients were engaged in occupational therapy in their own homes.

CHIROPODY

During the year five chiropodist were appointed and forty-eight clinics were commenced in many parts of the county, centred on Paignton, Barnstaple, Honiton, Plympton, and Newton Abbot, with the Chief Chiropodist working the area around Exeter. Unfortunately the chiropodist for North Devon resigned in September and it was impossible to fill the post before the end of the year.

The service, formerly for the elderly, physically handicapped, and expectant mothers, was extended during the year to cover the mentally disordered and school children. Apart from persons in receipt of National Assistance, and school children, a charge of 2/6 per treatment is made (4/- for domiciliary visits).

The number of persons seeking treatment has rapidly increased, so that by the end of the year most clinics had a long waiting list, and many as much as three months before treatment could commence. This unfortunately defeats the object of the service, as many elderly persons can lose their mobility and become in need of residential care whilst awaiting attention.

NUMBER OF TREATMENTS GIVEN TO PATIENTS

Areas	*Total Treatments*
Exeter	2,014
Honiton	2,561
Barnstaple (suspended in September)	1,791
Paignton (commenced in April)	—
Newton Abbot (commenced in December)	2,032
Plympton (commenced in Apirl)	1,642
Total	10,040

County Clinics have now been established at the following places:—

Alphington
Ashburton
Axminster
Bampton
Barnstaple
Bere Alston
Bovey Tracey
Broadclyst
Buckfastleigh
Budleigh Salterton
Chagford
Cheriton Bishop
Combe Martin
Crediton
Cullompton
Dartmouth
Exmouth
Hatherleigh
Holsworthy
Honiton
Instow
Ipplepen
Ivybridge
Kingsbridge
Kingskerswell
Kingsteignton
Modbury
Newton Abbot
Ottery St. Mary
Paignton
Pinhoe
Plympton
Plymstock
Salcombe
Seaton
Sidmouth
South Brent
South Molton
Stoke Canon
Stoke Gabriel
Teignmouth
Thorverton
Tiverton
Topsham
Torquay
Torrington
Totnes
Winkleigh
Yealmpton

A service by voluntary organisations, mostly participating in the county scheme, covers much of the rest of the county.

AMBULANCE AND HOSPITAL CAR SERVICES

Once again there has been a continued increase in the work done both by the Ambulance and Hospital Car Services, as will be seen from the figures below. The steady upward trend in the number of patients carried is expected to continue in parallel with the several stages of the Hospital Plan.

	1961	1962	*Comparison*
Ambulances			
Patients	63,002	65,776	+ 2,774
Emergency Calls	9,179	9,337	+ 158
Mileage	710,345	730,860	+ 20,515
Hospital Car Service			
Patients	103,267	185,003	+ 81,736*
Mileage	1,890,668	2,047,270	+156,602
Hired Cars			
Patients	4,757	5,029	+ 272
Mileage	13,093	17,199	+ 4,106

* Figures not comparable. See notes below.

Ambulances

The increase in the number of patients carried by ambulance, compared with 1961, was 4.4% but the mileage travelled by ambulance increased by 2.9% only.

Radio Control

Radio control has proved itself in the Torbay Area where the increase in the number of patients carried has been dealt with without any additional staff or vehicles. It is certain that without radio control extra staff and vehicles would have been required in this Area. It is hoped that the introduction of radio control to other areas will mean that the rise in the cost of the Ambulance Service will not be as steep as it otherwise would have been.

One incident occurred during the year when it was found that radio was of great assistance in dealing with an emergency. This was when there was a railway accident at Torquay, involving 13 casualties. Following the incident, which was dealt with most efficiently by the ambulance personnel, British Railways sent a letter expressing their sincere appreciation of the ready and willing assistance rendered by the ambulance personnel. and stating that they were most impressed at the speed at which the men arrived at the scene, and with their conduct in dealing with the emergency.

Co-operation with General Practitioners and Hospital Medical Staff.

During the year joint Conferences have been held with representatives of the General Practitioners and Hospital Medical Staffs at which ways and means of increasing the efficiency of the Ambulance Service, and ensuring that it is run with the utmost economy, have been discussed.

The Voluntary Organisations

The excellent service given by St. John, the British Red Cross Society and the Hospital Car Service continues.

The number of occasions on which volunteers manned the ambulances is slightly down on last year, but the total is still a very impressive one. Thanks are due to the Officers and members of St. John and the British Red Cross Society, and in particular Mr. Johnson, the Ambulance Liaison Officer, for the enormous amount of time they spend on ambulance work.

Hospital Car Service

Miss Bell and her Area Transport Officers continue to run the Service very efficiently and are keeping up with the ever increasing demands on their services. The Council is deeply indebted to these loyal and public spirited individuals whose efforts result in a considerable saving to the Council.

The work undertaken by the Hospital Car Service increased by about 7% during the year. Figures in the table above relating to patients carried by the Hospital Car Service for the two years are not comparable as the method of calculating the number of patients carried was brought into line with the method for calculating the ambulance patients during the year. This method involves counting a trip to and from hospital as carrying **two** patients.

Air Transport

Since my last report there has been only one occasion on which I considered it essential to ask the R.A.F. to provide air transport for a seriously ill patient who required emergency treatment. This was on the last day of the year when the blizzard had made it impossible for vehicles to get within some miles of the patient who was suffering from an abdominal obstruction. I understand that the use of the helicopter in this case undoubtedly saved the patient's life.

Civil Defence

An examination of the functions, organisation and training arrangements of the Civil Defence Corps has been carried out by the Home Office which has resulted in certain decisions being taken affecting the terms of service of volunteers. The conditions on which volunteers offer services have been varied to provide that:—

(*a*) retention of membership will depend on the fulfilment of precise obligations;

(*b*) the enrolment will be for specific periods of time, and,

(*c*) the importance attaching to membership of the Corps will be recognised by payment of an annual bounty to those undertaking special obligations.

There will be no change in the functions of the Corps which, in the case of the Ambulance and First Aid Section continue to be:—

(*a*) administering first aid to casualties;

(*b*) organising stretcher bearing and,

(*c*) transporting casualties to Forward Medical Aid Units and as necessary to Hospital.

It remains to be seen whether this re-organisation will result in a large increase in the number of active volunteers. Should this be the result the present staff would be unable to cope with the task of supervision without some help, especially in view of the fact that the Home Office expect a greater degree of supervision of training from County Heads of Sections in future.

Efforts are continually being made to make Civil Defence Training more attractive and to this end a " Methods of Instruction " Course was held last autumn which was attended by Instructors from the Ambulance and First Aid Section.

CHILD HEALTH SERVICES

This section of the Department is concerned with the health of every child between the ages of 2 and 16 years, the extremes of this age range being determined by provision made for handicapped children.

This administrative division, introduced in 1961, encourages an outlook of " Wholeness." A child who is handicapped either physically, mentally or socially is still primarily a child, and our concern is with his optimum development into a healthy, useful citizen within the context of the whole group, which is reflected in the trend to integrate handicapped children into the community.

The work covers the School Health Service, the care of Handicapped children either in their own homes or appropriate schools, registration and supervision of persons who care for children as daily minders or in day nurseries, and the general care of " special families."

DAY NURSERIES AND CHILD MINDERS

There are no Local Authority Day Nurseries in the County but nine are run privately and registered with us. The number of Child-Minders has increased steadily and at 31st December stood at 21. In large part this is accounted for by national publicity of the Play Groups Association, a body formed in London in 1961 by a group of mothers who were concerned at the lack of nursery school provision under the Ministry of Education.

In general material standards are high and the motives inspiring such groups are creative rather than necessitated by circumstances; that is the mothers are seeking company for their children in a setting of constructive play, not looking for somewhere to leave their children while they go out to work. Many of those who apply for registration have had either teaching or nursing experience, and they are making a useful contribution in supplying a genuine need. It seems even the infants mature more early!

SPECIAL FAMILIES

Early in 1962 it was realised that so much experience had been gained in the means of helping these families that it was now possible to crystallise arrangements for their care at field level rather than centrally, the latter remaining as a final point of reference only. Local co-ordination meetings are held as required and whichever officer convenes the meeting takes the chair and is responsible for issuing reports to the various departments concerned; this has reduced the necessity for meetings of senior officers and apart from considerable saving in time and travel this system enables local staff to take more responsibility, their work becomes more rewarding and liaison with other departments more personal: a credit balance in every way.

Towards the end of the year a Group Adviser, Miss McGilvray, was appointed who also has particular responsibility for the special families throughout the County: there are 153 on the active register. Any Health Visitor who would like a second opinion contacts Miss McGilvray and they discuss and often visit together: this in itself may avert the need for a local co-ordinating meeting and it does seem that the service is now offering greater possibilities of prevention. This does not mean that special families will soon be a pattern of the past: this hard core is with us for a long time yet as it is composed of individuals who for one reason or another are inadequate within the context of contemporary society, and as the latter becomes more " advanced " so the misfits appear even less adequate. But as we improve our understanding of their needs we can learn to anticipate a breakdown and the more local the rescue service the quicker we can underpin to prevent disaster.

SCHOOL HEALTH SERVICE

It is interesting that the trend in this Service is also towards a fuller appreciation of our interdependence. This is shown by the extension of the revised scheme of medical examinations, which requires close co-operation between doctor, teacher and parent. The same principle applies in the field of Health Education and the development of Discussion Groups, reference to which is made in the main body of the report.

The increasing interest in special clinics such as Hearing Assessment and in individual surveys undertaken by Medical Officers may appear to contradict this trend of relatedness, but in fact it is a healthy corollary, showing that as general standards of health improve more attention can be given to particular defects.

ROUTINE MEDICAL INSPECTIONS

Routine Medical Inspections continue to take up a major portion of the School Medical Officers time, and the number of inspections carried out vary little from year to year. The precentage of children found unsatisfactory in all age groups last year averages 1 in 400 (see table at end of book) which is considerably lower than the overall average in the previous 2 years (3 per 400 children examined). Individual reports by the School Medical Officers on the findings at medical inspections are very interesting and excerpts from these reports are quoted under the heading " Special Reports."

EXPERIMENTAL SCHOOL HEALTH SCHEME

Following the success in Plympton and Tavistock areas it was decided to extend this scheme to four further areas in 1962 and Dr. Wildman reports as follows on the progress of the scheme in Paignton:—

" Briefly all school entrants at primary schools together with all school leavers at secondary schools will be given a full medical

inspection with the parents present if possible, as at present. However only certain children in the eight plus and eleven plus age groups will be actually examined, and they will be selected by the School Medical Officer from previous medical records, a personal knowledge of the child, perusal of a comprehensive questionnaire previously sent out to parents, and after consultation with teachers and the school nurse. There is also provision for parents to request their child to have a full medical examination, even if there is no other reason for deciding that one is necessary. It is hoped that this new method will enable more time to be devoted to those children who from a medical viewpoint really need extra attention. The scheme is flexible and teachers and parents can always have children sent up for a ' Special ' medical examination should the need arise, so I feel happy that with the co-operation of all concerned every child needing medical attention will be seen. The school medical cards of children reviewed, but not actually given a medical inspection will be given an appropriate endorsement by the school doctor.

Before the scheme was introduced to Paignton I attended a Head Teachers' meeting when I was given an opportunity of explaining matters, aided by a comprehensive statement issued through the Education Department giving its blessing to the experiment. ' Experiment ' is the operative word, and it will be interesting to see how the scheme functions in Paignton during the coming years. By and large the Head Teachers are as enthusiastic about the idea as myself, so we are off to a good start."

SPECIAL REPORTS

The following reports have been received on special problems arising out of school medical inspections.

EARLY MATURING

Dr. Budding did a very small survey in the Autumn Term of 1962 (i.e. the first term of the school year), of all girls in their first year in the Secondary and Grammar Schools in her area, i.e. aged 11+. It was found, although the numbers were not very large, that in each school 15 per cent had started menstrucating (this means that about 15 per cent had actually started whilst in their Primary Schools, as the survey was done at the beginning of the Autumn Term). It was also brought out very forcibly that a surprisingly high percentage of the remaining 85 per cent were completely ignorant of the whole matter, and in these cases they were each given a leaflet to read at home and show their mothers. They accepted these quite well, and appeared to treat them as very private property, not showing them amongst themselves in little giggling groups. There have been no complaints from mothers, and one or two thanks, so presumably the parents are grateful. It does, however, appear to me that they have been failing in their duty to their daughters to give them no indication of these matters even when attending a big senior school. At least two schools have approached me on this subject, as the Domestic Science Mistresses have been shocked at the

ignorance, and sometimes the bad psychological effect on these girls, perhaps starting to menstruate for the first time in school. In these schools we did run courses in conjunction with the Domestic Science course.

It was interesting that in this small survey there appeared to be no firm relationship between maturity and home background or intelligence, i.e. the percentage in each class whether ' G ' stream or top Grammar, was constant.

ENURESIS ALARMS

Dr. Archer reports:—

Those allocated to my area have been kept constantly in use during the year; each apparatus can treat three to four patients a year. We have had three complete failures during the year—one girl of thirteen refused to sleep in her bed when the apparatus was set up in it. Nothing could persuade her to alter her mind and the equipment was returned after a couple of weeks. Another family resented being woken by the buzzer and the Health Visitor found that the apparatus was not, in fact, being used. A third child had had the alarm for several months and always manages to continue to sleep soundly through the alarm. One girl of fifteen treated in 1961 has needed a period of reinforcing treatment in 1962. Apart from these cases, cures have been regular and complete; most parents are extremly grateful for the opportunity to use the apparatus and one feels that this is a worthwhile service.

Dr. Browning reports:—

These are being used for almost all children aged nine and over who wet the bed regularly in spite of various drugs, fluid restriction, lifting out, and elementary psychotherapy. I propose to start shortly trying the eight-year olds: it will be interesting to see whether the average eight-year old is sufficiently integrated upon being awakended summarily from deep sleep, to know what to do when the alarm goes off. This is presumably the limiting factor with regard to age.

Dr. Budding reports:—

These have continued to give excellent results in carefully chosen children. However, in at least two cases the parents have preferred coping with the child's wet bed rather than suffer the inconvenience of themselves, and in some cases the whole house, being awakened in the early hours by the buzzer! It is to be hoped in these cases that the condition will be tolerated with no adverse repercussions on the child.

FOOTWEAR invites comment from two of the Medical Officers:—

Dr. Archer says that one of the points most frequently discussed with mothers both in school and in Welfare Centres is the care of the feet and the provision of suitable footwear. Quite evidently parents are very much aware of the importance of healthy feet and know that good footwear contributes to general good health. They are

anxious for help and advice.

I am sorry to see in the Child Welfare Clinics the popularity of the round heel on shoes for babies and toddlers. Parents pay five or six shillings extra for this design of shoe under the impression that they are buying the best for their child. One has only to watch a baby trying to stand and move in this type of shoe to realise how bad they are—once the body centre of gravity begins to move backwards these shoes act as a slide and the child's only means of avoiding a fall backwards is by grabbing anything that offers, sometimes with disastrous results. I have known children put into these shoes just as they started walking alone who gave up any attempt at walking without support after one or two frightening falls. Many mothers imagine that shoes are necessary as soon as a baby becomes ambulent to save wear and tear on the feet! Some of them learn by sad experience that shoes can be more permanently traumatic than normal locomotion.

There are two main footwear problems in later childhood. The first concerns the insufficient variety in combinations of length and width; the more expensive makes of shoe naturally offer more choice but even so there are some children at either end of the normal range of foot-shape that can never be found entirely satisfactory footwear from stock sizes. Immediately before the growth spurts most children's feet seem to lengthen proportionately more rapidly than they broaden, so that for a time shoe fitting becomes a special problem which is aggravated by the fact that growth is so rapid at these stages that shoes often outgrow before they are worn out.

The second big problem is one of fashion. I am often invited to intervene in a tussle between mother and daughter concerning suitable footwear. With a certain amount of sympathy towards both sides of the discussion, one can only point out that whereas shoes come and go, feet have to be made to last a life time.

Dr. Budding reports:—

Incipient Hallux Valque is always with us, and I have noticed no great increase recently. There is perhaps a slight increase in flat feet due to obesity, but most of the children cling to their obesity, and put up with their flat feet. I think the foot defect from girls wearing " casuals " will be shown more in a few years time, but at present the only noticeable fact is the peculiar flat-footed walk which they have to adopt in order to keep their shoes from falling off—most unattractive and undoubtedly uncomfortable. I think perhaps the problem in the next few years will be amongst boys, as I have been shocked to see the number of Upper Sixth Form Grammar School boys following the prevailing fashion of " Winkle Pickers ".

HEARING AIDS

Dr. Archer reports these are now being used for the treatment of patients with less severe hearing loss than was formerly thought to warrant such means, the reason for this is highly significant and justifies a new approach to the problem of the use of amplification of sound in hearing loss, particularly in children. If it was felt that the

patient could, by any means, get along reasonably well without it, a hearing aid was not prescribed. A hearing aid still tends to be regarded as the last resort of the partially deaf patient who cannot " get by " without it.

The improvement shown in the unaided hearing of patients who have used an aid for some time suggest that a more positive and optimistic outlook is justified; that hearing aids can, in suitable cases, be used as a means of re-educating and restoring hearing rather than as a method of making hearing loss less of a handicap. In following up the progress of our patients with hearing aids improvement has been evident in the pure tone threshold of the ear receiving amplification from the aid. This has led to the routine provision of ear moulds for both ears so that the patient can alternate amplification to the benefit, we hope, of both ears. Tentative experiments are now being made in the use of amplification in both ears at once by means of two separate aids. Since localisation of sound depends on binaural hearing the potential importance of this trial is immediately evident, but the possibility of the simultaneous re-education of hearing in both ears as a long term achievement is an added inducement. Following the same line of thought, it seems reasonable to explore the usefulness of amplification as a means of improving persistent bilateral hearing loss of a moderate or even slight degree by re-education. In the past there has been a tendency to question the original diagnosis and assessment when a hearing aid patient has later shown adequate unaided hearing; in fact, we should be encouraged to regard hearing aids as potentially curative rather than as palliative treatment in partial hearing loss whether bilateral or unilateral.

HEARING ASSESSMENT

Dr. Solomon: The close co-operation and interchange of information between the Hospital and Local Authority Service was most welcome, and certainly to the benefit of the patient. Both Mr. Bradbeer (E.N.T. Consultant) and Dr. Haas (Paediatrician) have given valuable help and encouragement in this time-consuming and sometimes frustrating work with the very young children.

The appointment in May 1962 of a Peripatetic Teacher of the Partially Hearing (Miss Meredith) to work exclusively in South Devon, meant that many children wearing Hearing Aids, and especially pre-school children, had regular help and instruction for the first time. In September, Miss Dangerfield commenced work as Audiometrician in the same area. Both ladies have already proved valuable members of the Hearing Assessment Team because of their sympathetic attitude towards the children and their enthusiasm for their work. It was possible to open the new Unit for Partially Hearing children at Westhill Primary School in the Spring. Miss Ross, Teacher of the Partially Hearing, who is in charge of the Unit, soon had the confidence of the 7 children, and already parents and others have remarked on the improvement in their speech.

Tables X and XI contain figures relating to the Hearing Assessment Clinics).

HEARING TESTS IN SCHOOLS

Dr. Archer:

Most of our new patients come to the Bull Meadow Road Hearing Assessment Clinic as a result of screening for hearing loss in Schools. In my area school entrants are tested before the School Medical Inspection; word lists are used and each ear is tested separately—speech as well as hearing is thus assessed. Any child who fails has a second test in school and, if unsatisfactory results are repeated, is referred to the Clinic for full assessment. Between the 5 year old and the 8 year old medical inspection the Health Visitor screens again and also tests any children transferred to the school from elsewhere.

Towards the end of 1962 we had the opportunity of testing the efficiency of this procedure by sweep audiometry in two schools where word testing has been in use for the last five years. The sweep was deliberately carried out at 10 dec. (American standards) so that the threshold audiograms of the children who failed at this level would give us information about the hearing of children in the lower ranges of normal and about the best level at which to conduct further sweeps. Six frequencies from 250 cps. to 6000 cps. were swept. The results are set out below:—

Tested 292

Failed at 10 dec. 65 all had pure tone threshold tests.

Results of Threshold Testing:—

Average loss of worst ear less than 10 dec.	34
Average loss of worst ear 11 to 15 dec.	22
Average loss of worst ear 16 to 20 dec.	7
Average loss of worst ear 21 to 30 dec.	2
Average loss of worst ear 30 dec. or more	0
	65

The ages of these children ranged from 5 to 11 years. It is interesting that even when sweeping so near threshold 78% passed. It has been suggested that hearing loss amounting to less than an average of 30 dec. in the better ear does not require treatment. None of the children tested had anything approaching this degree of loss. Thus, sweep audiometry did not reveal any unsuspected hearing loss in these children who had already been screened by routine word testing.

In line with the national trend the audiometers in use in East Devon are now being re-calibrated to British Standards.

Dr. Browning:

Michael Reed Hearing Test Cards are used to screen all school entrants and all children with dyslalia. Those who fail on more than one card are referred for an audiogram, and approximately half of these have significant hearing loss shown by the audiogram. It is quite a useful test used in this way; and also it helps to establish rapport with a five-year old very quickly at the beginning of the inspection.

OVERWEIGHT CHILDREN

Dr. Archer reports:—

There are too many overweight children in my schools at present. Most of these children are overweight because of family eating habits which parents see no necessity to modify although they often express concern at the child's obesity. The Meals Supervisor in Schools can be a tremendous help in persuading these fat and hungry children to refrain from second and third helpings of calorie-rich foods. They do need most sympathetic and patient help in their attempts to reduce their obesity, about which they are almost always uncomfortably self-conscious, and they are delighted by any success in weight reduction.

A group of children with special weight problems are those on prolonged antibiotic medication and restriction of exercise following rheumatic fever or other recurrent infections. Both the medication and the restriction of exercise favour excessive gain in weight when it is particularly important for these children to maintain a reasonable gain. Only regular weighing and careful supervision can provide just the right management. It is most unfortunate when the illness comes in early adolescence and the child leaves school after a year or so without regular exercise, overweight, and out of condition, and ill-equipped physically to start earning a living.

Dr. Solomon:—

Ten years ago I carried out a **Survey of Heights and Weights** of Torquay school children and compared them with those published for L.C.C. children for 1949. In 1960-61 the heights and weights of all school children in my area were recorded in comparable conditions to the previous Survey—and compared with the L.C.C. figures for 1959. There was an increase in **weight** in all age groups in both sexes compared with 10 years ago—but specially in boys aged 12 to 15, who were on average 16 lbs. heavier. The average gain in weight for the same age-group in the L.C.C. in the 10 years was only 8 lbs. By comparison there was no significant gain in weight in girls in the 10 years period compared with the L.C.C. There was, however, no increase in height in Torquay boys or girls compared with L.C.C. in that period except in the 12 to 15 age group where the Torquay children were $1\frac{1}{2}$″ to 2″ higher, and the L.C.C. children only $\frac{3}{4}$″ to 1″ higher. These surveys have provided not only interesting comparisons but also basic local standards which are obviously different from those in L.C.C. area.

Verrucas

Dr. Solomon:—

Following the pilot survey of Verrucas in 2 schools last year, a full survey of all children with Verrucas in 7 Secondary Schools (pop. 3,458) was carried out. 93 children were found to have

definite Verrucas—of which 83 were unaware they had them and had had no treatment. In the same schools 30 children were found to have **Athlete's Foot** of whom 24 were untreated. The **age incidence of Warts** had always interested me, so the children in all the schools where termly hygiene inspections were carried out were inspected for warts on hands, face, eyes, etc. (4,765 children including Boys' and Girls' Grammar School children). 255 children had Warts (5.33%) which were significantly common in the 8 to 10 and the 13 year old age group.

VISION TESTING

Dr. Archer reports:—

We find the Stycar Vision Test, devised by Dr. Mary Sheridan, most satisfactory for the first vision test in school. In this test each letter is presented alone as a black letter on a white card at 20 ft. from the child, in sizes varying from 6/60 to 6/6; instead of naming it or drawing it in the air, the child finds and points to the similar letter on a key card placed in front of him. Young children can match shapes before they can reproduce them by drawing or naming letters. Matching eliminates the ambiguity which sometimes results from the uncertain efforts some immature children make to reproduce the shape of letters in the air. These are often just the ones whose vision should be checked with special care. It is always interesting to note, while testing children by this method, the wide variation in visual memory at this age. Some children can search through all the letters on the key card for the test letter they are matching with never a second look at it; others have to keep reminding themselves by looking back to the test letter. Yet other children are satisfied with an approximation, for example, V for X or U for O, until reminded by the tester to take another look at the test letter when they see their error and match it correctly. These observations at the outset of a child's school life have some significance since visual memory plays an important part in learning to read and write.

During the year, Dr. Hunt carried out a survey of the incidence of visual defects discovered at the annual vision testing at nine primary schools in his area. He records:—

" At the school entrants examination it was found that 27 of the 326 children tested had defective vision (8.2%). 18 of these children were known to have had defective vision before school entry but nine children had vision defects discovered for the first time. Seven of the nine children ultimately required treatment for these defects. The survey indicated that approximately 2.1% of children on entry to these schools had vision defects which required treatment and which had been discovered for the first time as a result of the vision testing carried out at these schools."

HEALTH EDUCATION

DISCUSSION GROUPS

Dr. Budding writes from the Tavistock area that the Psychiatric Group Meetings with Medical Officers, Health Visitors, Psychiatric Social Workers and Psychiatrists, continued to be most helpful, and that it is hoped to expand these next year.

A similar group meets in the Plymstock area and the Health Visitors find the discussions of particular problems a really constructive help in their work with the families.

Dr. Solomon comments that the closer co-operation between Hospital and Local Authority Staffs at all levels had been apparent in recent years. This encouraged the formation of a Discussion Group for Medical Officers, Health Visitors and Social Workers for in-service training and information about recent advances in specialist subjects. Both Dr. Haas (Paediatrician) and Dr. Johnston (Psychiatrist) have had monthly half-hour Discussion Groups which have proved very popular and in which all have learned much from each other.

PERSONAL RELATIONSHIPS

On the subject of personal relationships Dr. Budding recounts what she describes as " an interesting and somewhat shattering experience "—

" During the Spring Term I was invited to be one of a panel at a meeting of 200 school girls aged 14+ from South West Devon and Plymouth, who had been discussing with the Rev. Chad Varah the question of personal relationships. The rest of the panel consisted of a psychiatrist, a dentist and a housewife—all of us rather unwilling starters. We came away with mixed feelings; how much good was done was debatable, but the questions were remarkably frank and I think the answers were equally so. The panel was unanimous in trying to put the whole matter in perspective, using the analogy of an iceberg with the physical side there, but only as a part of the greater whole."

From facts gathered from reliable sources, as far as her area is concerned, Dr. Budding concludes that there has been no deterioration in morals in the past 50 years, and at present a serious problem does not exist. She adds as a final comment " the senior schools are doing all that can be reasonably expected of them in this matter —further action lies with the parents."

SMOKING

Dr. Browning reports that a pilot scheme was carried out in which all pupils aged thirteen and over were instructed in the dangers of cigarette smoking. No difficulty was found in retaining their attention, in groups of not more than forty, for thirty to forty minutes, without visual aids. The problem was to get them to accept the facts in the face of steady, adverse propaganda and examples from so many parents and other adults with whom they associate.

THE SCHOOL DENTAL SERVICE

STAFF

Mr. J. D. Sykes, Principal School Dental Officer reports.—

Early in the year the retirement took place of Mr. J. E. B. Smith and of Mrs. W. Sabine his dental surgery assistant, after 32 years and 31 years service respectively. Mr. I. Blake succeeded Mr. Smith in the Newton Abbot rural area. It is with regret that the tragic death of Mr. T. B. H. Wood is recorded. During the short time he worked at the Barton Clinic in Torquay he made himself most popular amongst those with whom he came in contact. Mr. M. V. C. West who had been a full time officer in Tiverton and later part time at the Castle Road Clinic resigned in May. Miss R. Stephens one of the first group of Dental Auxiliaries to complete the two year course at the New Cross Training School started work in September in the second surgery at the Torquay Castle Road Clinic under Mr. Derbyshire. Mrs. P. W. Goodman began working six sessions a week at Tiverton Clinic in November. Miss J. Pattison was appointed Dental Hygienist in September and whilst her training enables her to undertake clinical duties of a prophylactic nature her principal duty will be to give instruction in oral hygiene.

At the end of the year there was still no dental officer in the Okehampton area whilst treatment in the Totnes and Barton areas was done by part-time dental officers working six and four sessions a week respectively. Full-time officers had been appointed for these three areas however to take up duties early in 1963.

TREATMENT

Whilst there was a 9% increase in the number of sessions worked the increase in the number of children inspected was only 6% and in the number treated only 3%. This is because each child treated attends more often and needs more treatment. Other changes in the statistical items in Table XII are as would be expected except for one which calls for comment. The overall increase of 10% in the number of fillings done is due almost entirely to a big rise in the number of fillings in temporary teeth. The page opposite shows how over the past ten years the number of these fillings has risen, slowly at first, more rapidly later and abruptly last year. Study of the returns of individual dental officers shows that whilst all have done more such fillings there is superimposed on this increase a large number done by a newly appointed member of staff. Not very many years ago a dental officer who did fillings in temporary teeth invited a rude letter or visit from an angry parent. He now risks the same for omitting to do so. There is a growing realisation of the necessity for preserving these teeth and Mr. Clarke reporting on the number of children found to require orthodontic treatment says " I feel that the only way the number can be kept under control is by more attention to the primary dentition."

DETAILS OF DENTAL TREATMENT PER 100 CHILDREN

Type of Treatment	1952	1953	1954	1955	1956	1957	1958	1959	1960	1961	1962
Fillings:											
In Permanent Teeth	130	135	136	144	165	184	161	166	182	187	185
(No. of Teeth Filled)	(114)	(118)	(117)	(124)	(144)	(162)	(147)	(144)	(158)	(160)	(156)
In Temporary Teeth	17	16	20	22	22	21	21	27	37	37	55
No. of Teeth Filled	(14)	(16)	(20)	(20)	(21)	(21)	(21)	(25)	(34)	(34)	(49)
Extractions:											
Permanent Teeth	16.1	16.5	18	25	27	27	25	28	33	25	22
Temporary Teeth	80.2	67	79	72	83	77	65	70	71	67	57
Other Treatments	100	99	92	103	118	128	126	118	132	175	147

The new system of invitation for treatment came into operation at the beginning of the year. Now all children who at inspection are found to require treatment are offered it unless it is apparent that they are under dental supervision elsewhere. Previously only those whose parents had opted for school treatment when the child first entered school were offered treatment. Dental Officers report that this has had the effect of bringing into the scheme children previously excluded because of this early refusal. They also point out that the new system in effect invites those already in the scheme to opt out. Mr. Clarke writing about the new invitation form CH/D/32 says " This form . . . . has been well worthwhile. The acceptance rate among the Primary School children for treatment has been very much higher and I can find very little evidence at the moment for any more refusals among the Secondary Schools than before." Miss Shapland says " I cannot claim that the number of acceptance forms has risen; some have changed to refusals but others have changed to acceptances—the important thing is that instead of a school being divided into Red Forms and Black Forms (the old standing " Refusals " and " Consents ") the children are all now potential patients. This is far more interesting to all concerned and most of the Head Teachers are in favour of the arrangement." The general impression is that there has been gain in the proportion of children brought under treatment though the figures available appear to indicate the reverse. These show that the acceptance rate in 1961 was 79% and 70% in 1962. In 1962 however 2,500 additional children were offered treatment and most of these were the old ' refusals ' who previously were not offered treatment and who for the most part are unlikely to accept treatment unless driven to do so by pain or the threat of it.

In the knowledge that the dental man-power of the country was inadequate to satisfy the overall demand for treatment, the Local Authority was designated the Priority Service; its function to assure treatment for the priority classes, the mothers and children. In the event the disparity in remuneration between the Local Authority Service and the General Dental Service resulted in loss of staff from one to the other. For a time the " Priority " Service was thus unable to meet the requirements of the priority classes of children and expectant and nursing mothers. In 1951 however the introduction of charges for adult patients resulted in some reduction in demand and increased the opportunitites for the priority classes to obtain treatment under the General Dental Services. The effect of this has been particularly noticeable in areas such as Devon where there is a relatively high concentration of general dental practitioners who now treat a larger proportion of children. The Local Authority Dental Officer is responsible for an allotted number of children in his area and is governed to some extent by the principle of " the greatest good for the greatest number." The general dental practitioner is responsible only for the number of children he chooses to accept and can therefore see each patient as frequently as he wishes. Inevitably the Local Authority Dental Officer finds himself with a much

larger proportion of the children whose parents do not appreciate the benefits of regular dental attention. It can reasonably be agreed that the Priority Service, which has the duty of inspecting all children in school, should concern itself primarily with those who will not of their own initiative look after themselves. It must at the same time be recognised that this has made the dental officers' work more difficult and less rewarding.

ORTHODONTICS

More cases were carried over from the previous year, and more new cases were started during the year, than in 1961. Because of the long distances involved, Mr. Peacock's visits to the north and east of the county were reduced in frequency, enabling him to use his time more productively nearer to his centre; the cases in those areas being treated by the Dental Officers under Mr. Peacock's guidance where necessary. Mr. Peacock writes "The apparent large number of cases whose treatment has been discontinued includes a number of cases who left Devon without leaving addresses, or have left for stations abroad, the fathers being Service personnel. I would like once again to stress the importance of recognising orthodontic cases at an early age, especially in the 8-10 age group, when early treatment can often prevent an anomaly getting worse. Post-normal occlusions are not always recognised at the routine inspections and, as these are more common than displaced teeth, particular attention should be paid to this." One looks forward to the time when it may be possible to arrange for every child reaching this age to have a routine inspection by the Specialist Orthodontist, for ascertainment of these abnormalities.

CLINICS AND EQUIPMENT

The new clinic at Plymstock was opened during the year. Unfortunately it was necessary to transfer some of the equipment from the old clinic, and it looks somewhat out of place in its new environment. An air turbine unit has since been added.

The Mobilactor Unit with air-turbine was transferred from Kingsbridge to Honiton, and replaced with a portable air-turbine unit which can also be used at Dartmouth Clinic. A similar unit has been provided for use at Tavistock and Plympton, and another for Paignton Clinic. These three units can also be used in mobile clinics or elsewhere if required. An air-turbine mounted in a mobile instrument cabinet has been delivered to Barton Clinic and, whilst it is not portable, it is transferrable. There are now ten air-turbines in use in the clinics.

Another mobile dental clinic was delivered in October, 1962, and taken into service immediately in the Culm Valley area. These clinics were originally intended, and up to now have been used, to cope with the problem of providing a service in rural areas, but there is much to be said in support of their use in urban schools which are separate from the static clinics by some mileage of busy streets.

All Heads of schools who have been host to a mobile dental clinic prefer this means of providing treatment to any other, offering as it does, most of the amenities of a static clinic, entailing no call on the school for accommodation, and reducing to a minimum the time of the child's withdrawal from school for treatment.

Mr. Dickson used a " mobile " at Oaklands Park Junior Training Centre, and found that the interest aroused enabled him " to carry out fairly extensive treatment, including the provision of a denture for one girl." He pays a warm tribute to the work that the members of the staff there are doing for these children.

Although the number is being reduced, there will still be schools to which it is impossible or impracticable to take a " mobile," and work has of necessity to be done using portable equipment in improvised surgeries. Mr. Blake refers to five of his schools, to which a " mobile " had been taken for the first time, as having had " in the past to be content with ' backyard dentistry ' ". Good dentistry has been, can be, and still is being carried out under these difficult and undesirable conditions, but these must prejudice the observer against the service. There seems to be no alternative which is not equally or more unsatisfactory in some other respect.

DENTAL HEALTH EDUCATION

Miss J. Pattison was appointed as Dental Hygienist in September and has given dental hygiene instruction to 2,900 children in 24 schools, and to 300 adults in 11 sessions of 9 different Associations. She has also been making and acquiring teaching material for future use.

Mr. Vowles describes an interesting trial conducted at the Dame Hannah Rogers School, with the enthusiastic help of the staff there. Many of these children are unable to manipulate a toothbrush effectively, and the manufacturers of a mechanical toothbrush have supplied a large quantity of these, together with conventional brushes for this trial. As the brush-head of the electrically operated instrument is guided horizontally along the teeth it rotates to and fro through an angle of sixty degrees in a vertical plane, giving that part of the brush movement that the children are unable to manage themselves with an ordinary toothbrush.

A controlled cross-over trial was conducted, involving two groups of ten children. One group used the mechanical toothbrush for two weeks, whilst the other used a conventional design. Carbol fuchsin plaque readings were taken before the trial, to give a base line, and repeated at the end of the first two weeks. The groups then reversed their roles for a further two weeks, and another plaque reading was taken.

The results showed that a considerable improvement occurred in the children using the mechanical toothbrush, the ratio being in the order of 2.8/1 when compared with the conventional brush.

TUCK SHOPS

Tuck Shops which mostly sell dental decay producing confectionery are common in our schools. Admiral Williams and Mr. Pomeroy both note and deplore a further increase this year.

It was reported last year that information had been obtained from a number of schools that were selling fruit and nuts instead of the more usual sweets and biscuits, and that a summary of this information had been compiled, as to sources of supply, ease of handling and profits to be earned. The availability of the summary was notified in the School Circular 61/6.

Twelve more schools applied for this summary during the year. It is clear that whilst apples present some marketing difficulties, dried fruit and nuts in packets prove just as profitable and equally acceptable as biscuits.

CONCLUSION

Once again I conclude by recording the appreciation expressed by members of staff for the co-operation and encouragement they receive from the teaching and secretarial staff of the schools they visit and to the members of the staff of the Central Repair Depot on whom falls the work involved in maintenance and movement of the mobile dental clinics.

SCHOOL OPTHALMIC SERVICE

This is run through effective liaison arrangements between the South Western Regional Hospital Board who provide two full-time and two part-time Ophthalmic Surgeons, and our own School Health Service staff. Dr. Chaturvedi and Dr. McCormick cover the North, East and Torbay areas of the County, Dr. Foxwell, Tavistock and Holsworthy and Dr. Searle Torrington and Bideford areas.

Annual vision testing is carried out in all the schools by the Health Visitors or Nursing Assistants and children with, or suspected of having defects are referred to the Ophthalmic Surgeons who visit the schools themselves in the rural areas, although clinic premises are used in urban areas where it is possible for such an arrangement to be economic of time.

Dr. Chaturvedi reports:—

" It is gratifying to find a readier acceptance and greater co-operation from the parents, not only of the spectacles but also of other measures of treatment, e.g. occlusion, with attendant better results, though a refractory minority remains.

" Another trend has been a greater desire to have " grown-up " frames. This has resulted in an increasing number of students, especially of the secondary schools, going to the opticians for the treatment of their eyes, because of the misconception that that is the only way to obtain the non-N.H.S. frames they desire."

EYE DISEASES, DEFECTIVE VISION AND SQUINT

	Number of cases dealt with
External and other, excluding errors of refraction and squint	1,453
Errors of refraction (including squint) ..	9,610
Total ..	11,063
Number of pupils for whom spectacles were prescribed	1,179
Total number of sessions held at schools ..	528
Total number of sessions held at clinics ..	280
Total number of school children seen ..	10,827
Total number of pre school children seen ..	813

SCHOOL PREMISES AND CLINICS

Dr. Archer comments:—

The most serious problem in my area is still that of accommodation both in schools and clinics. Every school in which I work is short of space which means that teachers and children are inevitably inconvenienced in order to provide somewhere for medical work. The kindness with which the staff-room or a classroom is vacated often astonishes me.

Dr. Browning writes:—

A special request from the Headmaster of Ivybridge Secondary Modern School for a regular consultation clinic on the school premises has been met by my attending, in the school medical room, from 1.30 p.m. to 2.00 p.m. twice a month. This short session is sufficiently used to justify its continuation and moreover the Headmaster is much pleased with the arrangement.

SPECIAL EDUCATIONAL PROVISION FOR HANDICAPPED CHILDREN

The numbers of handicapped children registered in the Department at 31st December were 1,193 of school age and 178 (ages 2 to 5 years). They are categorised as follows:—

	Ages 5 *to* 16	2 *to* 5
Blind	13	3
Blind Partially	24	9
Deaf	17	1
Deaf Partially	37	3
Epileptic	7	18
Delicate	109	—
Physically Handicapped	155	99
Educationally Subnormal	566	—
Maladjusted	65	—
Mentally Handicapped	—	45
Subnormal	183	—
Severely Subnormal	17	—

Handicapped pupils requiring education at special schools approved under Section 9(5) of the Education Act, 1944, or boarding homes, are shown in Table XIV (appendix),

Blind and partially sighted children continue to be placed respectively at the Royal School of Industry for the Blind at Bristol, and the West England School for Partially Sighted at Exeter.

Deaf and partially hearing children. Those severely handicapped are placed at the Royal West of England School for the Deaf, as are some partially hearing children who need more help than can be given by occasional visits from the Peripatetic Teacher of the Deaf.

TEACHING OF THE PARTIALLY HEARING

The county area is divided into two, each half having a peripatetic teacher of the partially hearing working in close liaison with the Hearing Assessment Clinics. Miss K. N. Meredith covers the southern half of the county and Mr. R. Marshall the northern half.

Miss Meredith reports as follows:—

" During May and June a preliminary survey of the Torbay area was made, visiting all known cases of hearing loss in pre-school and school age children. An Amplivox Speech Training Unit was in use as part of pre-school auditory training programmes and as a valuable adjunct in the work of speech correction in school children.

In addition to this teaching work a good deal of home and school visiting has been undertaken to check on the use of hearing aids, or to make preliminary assessment of educational background, speech, and practical effects of hearing loss in school of those due for attendance at the Torbay Hospital Hearing Assessment Clinics.

I would very much like pre-school children with no naturally acquired speech to be afforded half or full time attendance in nursery classes at school. Well before his fifth birthday the child who has received home training, whilst making progress towards acquiring speech and language, is nevertheless in need of opportunities for group play and activity and of general socialization, often as early as his third birthday."

Mr. Marshall reports:—

" The work starts with home training of babies and young children with, or suspected of having, a hearing loss prior to admission to school. Parent guidance is most important. It is often a matter of convincing the parents of the value of a hearing aid and of gaining their co-operation in encouraging the child to wear it. Problems which a partially deaf child presents are discussed and advice given on how to deal with such difficulties.

In most cases where a child has been found to have a significant hearing loss, I have visited the School and advised on placement in class indicating the extent to which the deafness is likely to prove a handicap. In cases where an aid has been prescribed the teachers co-operate in ensuring the aid is working and worn.

A most important part of the work has been done with six infants without normal speech and language who would undoubtedly have been unable to be integrated in a normal school without specialised help.

Liaison is maintained with teachers of the deaf in the County and the Royal West of England School for the Deaf, where there are 28 Devon County children in attendance.

Early in the year I started and ran a partially deaf unit with three children at West Hill School, Torquay. The Unit was equipped with a group aid for ten, a tape-recorder, a record player, a loop and each child was issued with a special Medresco aid for picking up loop induction. The unit was enthusiastically accepted by the head and staff, and in May Miss Ross, took over from me."

Physically Handicapped children attend Steps Cross School at Torquay, a day school catering for 100 children. Those who cannot attend daily for geographical reasons are placed in residential schools outside the County.

Delicate children are few and far between in the original meaning of this term, but quite a number of children are below par for one reason or another and these are mainly catered for by the provision of *BASILDON*, our convalescent home at Exmouth. During 1962 the occupancy rate averaged 80%. Matron and her staff have worked hard and unobtrusively, achieving some real transformations in the children they care for. There is still a great need for provision of this kind, particularly for children who have been contacts of a case of T.B. and whose resistance needs building up; for those from homes where for one reason or another standards are low and the

children's nutrition has suffered, and for those suffering from enuresis Matron has had some remarkable successes with this last group. It is particularly valuable to be able to arrange for children to go to Basildon during times of temporary family disorganisation or stress. They always seem to enjoy themselves and to come back looking very fit.

Maladjusted children are received into either Crichel Hostel at Totnes or The Gables at Willand, although a few are unsuitable for either and are then sent to Special Schools outside the County. Dr. Johnston reports that Crichel Hostel is now working at almost full capacity.

Educational Sub-Normal. We enjoy excellent liaison with the School Psychological Service in the selection of children for placement in our three residential schools.

The day E.S.N. schools are not yet functioning but we are beginning to plan selection of children for the one in the Torbay area. One or two of the Medical Officers comment on the amount of parental resistance to residential accommodation and although this is essental for some children it will be a great step forward when day placement is possible.

This group of handicapped children continues to be by far the largest, and we can expect at least an apparent increase when adequate provision is available. Dr. Archer and Dr. Budding make the following comments on the placement of E.S.N. children:—

Dr. Archer reports:—

Several educationally subnormal children from my area have been placed in residential schools during the year and there are still others ascertained whose parents have not yet accepted the opportunity of placement. One learns never to give up trying to persuade them since the most surprising and unexpected reversals of attitude occur. If the parents go to see the School suggested and meet the staff, the battle is won. I have yet to meet a child who is unhappy or a dissatisfied parent when placement in one of our residential special schools has actually been made. One mother came to tell me that she had taken her daughter to Maristow after refusing for three years to agree to her admission to a special school. The parents who refuse most vehemently, are often the ones who suddenly alter their minds and later become most enthusiastic.

Dr. Budding reports:—

I have had the advantage of being able to follow through some E.S.N. children with whose backgrounds I am familiar. There is no doubt that certain children benefit from **Residential** Special schooling, particularly those with poor home backgrounds and associated debility. Indeed, it is remarkable to me how a puny child with huddled up shoulders improves in stance, demeanour and

mental attitude, and develops a certain degree of self-confidence after an average of only two terms of regular hours and meals.

However, there are other children in residential schools who would I feel benefit just as much (and certain cases even more) if they could attend special day classes for E.S.N. pupils attached to ordinary schools. In my area we have one peripatetic teacher for backward children whose work is invaluable, and this should be extended if at all possible. There are, of course, also those children whose parents refuse to allow them to go away at all, and these are all too frequently the ones to appear in Juvenile Courts, who otherwise would very probably have had no opportunity to go astray in this way.

Mentally Subnormal

The developments in this field are tremendously exciting, both in terms of bricks and mortar and in attitudes: the two are by no means unconnected. Parents who find difficulty in accepting a mental handicap in their child are almost invariably helped to something very near rejoicing when they actually see our new Schools, and the children themselves are delighted and extremely proud of them.

It is important to realise what this means to parents: the buildings which most authorities had available until the passing of the Mental Health Act made better provision possible, were inadequate, often depressing and tended to give the impression that they were " good enough—the children wouldn't appreciate anything better." Unfortunately this gave concrete form to the mental anguish and resentment of the parents: the new schools help to restore their confidence and offer them hope for their children.

Reactions of children to the new school environment have emphasised the normality of their emotional make-up in many respects, and their responsible use of equipment and facilities to which most of them were quite unaccustomed at home or school has surprised and humbled even those who knew them best. This has been an object lesson which few of us will forget and which one must use as a corner stone in building their future. Their potential for achievement may well be beyond our present horizon, and whilst it would be foolish to indulge in too great an optimism we can safely, and in justice must, raise our sights in response to the target the children themselves have set us.

In this connection it is salutary to review the changing outlook over the past few years. When local authority provision was first made for the mentally subnormal child it was usually in a prefabricated hut, a village hall or a rambling old house—and was called, significantly, an Occupation Centre. The children went about 10 in the morning and were kept occupied by various means until 4 in the afternoon by unqualified staff, whose preserverance and devotion cannot be too highly praised: too often they were the only people who really believed in what they were doing. It is relatively easy for us now to see a future, but the credit for this belongs largely

to the men and women who bore the heat and burden of those early days.

From Occupation we advanced to Training Centre—this really was progress: from a passive filling-in of time we turned to a positive approach, a training in the elements of hygiene and social adaptation allied with instruction in productive craft-work and domestic skills. Facilities for training of staff increased too and it is now accepted that qualified staff are essential. Gradually this training has extended both in range of interest and in depth, until now it is quite widely accepted that we have arrived in the realms of education. By definition this is " to bring up a child: to train mentally and morally," and one might add " socially and emotionally ": we are doing just this in the schools for handicapped children as others are in the ordinary schools. The pace is different, the goals reached will be different, but the achievement is there and the ideals are the same—to help a child to develop as a whole person to the limit of his ability.

Dr. Archer comments:—

" It is highly satisfactory that mentally subnormal children are now getting expert teaching and care, either in Day Centres or at Oaklands Park, our residential centre. Their parents are appreciative of the benefit conferred on both the child and the family as a whole. While residential placement is quite evidently necessary in some family circumstances, the decision to take a young mentally subnormal child habitually out of his family for longer than the school day is a serious one. The opportunity now being offered at Oaklands Park however for care of mentally subnormal children for a short period in the summer, while parents have a holiday, is very valuable. One hopes it will be used increasingly as it becomes more widely known and accepted."

Dr. Budding writes:—

" It seems to be a remarkable fact that children from atrocious home backgrounds appear to accept the differing standards of home and boarding school with equanimity. They do not appear to contrast them in their own minds, and show no reluctance to return home or to return to school, although the material and mental environment may be diametrically opposed. It is fortunate that they appear to accept "home" for what it is, and the important home relationships good or bad, do not appear to be interfered with."

JUNIOR TRAINING CENTRES

The 1 Residential and 3 Day Centres continue to expand and show good results, the total number of children in training at the end of the year being 143 as compared with 129 in January. One of the great problems in Devon is the geographical one and the

difficulty of transporting children to and from Centres. It is hoped this will be eased when the two " 5-day " hostels are opened in 1963 at Barnstaple and Plymstock.

The increasing interest in the training and welfare of the mentally handicapped child, both by parents and the general public is very noticeable and is greatly encouraged by the open days held termly and the Parent-Teacher Association: Oaklands Park started theirs this year and it is planned to re-start at Plymstock when the new school opens, which will mean there is a Parent-Teacher Association at all the schools. Each Centre has its ever increasing circle of friends who provide many gifts and amenities thus adding to the happiness and well being of the children. The interest in the Training Centres is not only local, and Centres have received visits from well known celebrities, such as T.V. and radio personalities—as at Mayfield, Paignton, during the summer when Mr. Frankie Vaughan, Miss Dottie Wayne and Mr. Basil Tait spent an unforgettable afternoon entertaining the children.

When the new buildings have been completed in 1963 the Health Committee, by its forethought and planning will have provided accommodation for all Devon County Council children who are mentally handicapped and suitable for training.

SPEECH THERAPY

Speech is the last and most complex aquisition in man's evolution. It is intimately linked with his intellect and emotions and defective speech can be a severe handicap.

Speech therapy is concerned with disorders of speech, including communication, language, articulation and voice. Although many people believe that the nature of our work consists solely of the correction of faulty articulation this is far from the case. Many of the children we see do have disordered articulation but this may be a relatively minor aspect of the problem.

Frequently we see children whose incomprehensible speech is due mainly to emotional factors, in such a case it is probable that direct connection of the speech would be most undesirable: the speech therapist's efforts would then be towards remedying the underlying causes and encouraging the child's drive in the direction of normal development. A similar sounding speech defect may be the result of neurological disorder and would require a completely different treatment. A child with a repaired cleft palate may need to learn to make sounds in a special way to cover his deficiency effectively.

Few speech defects have a single cause and the individual nature of each defect and its relationship to the child's whole personality and development is most important when deciding on the type of treatment and the best time for it. One must take into account the causes, past and present emotional attitudes, the child's personality and abilities, the type of home co-operation, and the limitation of available resources.

Our work with children involves treatment and advice for all kinds of speech disorders except those due to a marked hearing loss. It includes those due to physical abnormalities; to neurological disorders such as cerebral palsy; facial paralysis; disorders of the concept of space; disorders of auditory perception and memory; emotional disorders affecting speech; cases where voice is excessively nasal, grating or abnormally pitched; loss of voice, delayed or absent speech development; stammering which may occur as repetitions or blocks. Where possible, early referral for advice is always desirable but it is especially so in the last two types of case.

There are a small number of children with severe speech defects whose parents are unable to attend the clinic or to carry out advice following home visits. These unfortunate children are completely deprived of the help they need. We hope that one or two of them will be able to spend a short period at our Children's Convalecsent Home where they can attend the local speech clinic and receive help from the staff between visits. No doubt the improvement in their general physical health under these conditions will enable them to respond more readily to speech therapy.

Unfortunately, there is still very little provision for the treatment of adults within the County, but there is an agreement between the County and the Regional Hospital Board for a token service on a sessional basis at the North Devon Infirmary, Barnstaple, Torbay Hospital and City Hospital, Exeter. Further sessions and a wider coverage of this area is still very badly needed. Efforts to give domiciliary treatment to adults have been made, but this is very far from adequate as the children naturally have priority in a School Service and in some areas the waiting lists are still very heavy.

It has been possible, however, under the aegis of Mr. Bradbeer, the E.N.T. Surgeon in the Torbay Hospital, to form a Laryngectomy Group for patients living in this area, and at their first meeting they were joined by a " Laryngectomy " from Plymouth. It is hoped that a similar Group may be formed shortly in the East Devon (Exeter) Area.

During the Spring Miss MacMillan left the County having worked in the Torbay area for 5½ years. Miss Hodgkinson, an Australian therapist working at the Dame Hannah Rogers School for Spastics, took over the Torbay Clinic until Miss Monaghan was

appointed in the Autumn. At this time, too, Miss Coleman was appointed to the Barnstaple Area. Tavistock, Okehampton and Holsworthy continue to be without any Speech Therapy Service although it is hoped that the establishment may be increased so enabling this area to be covered.

As the staffing position eases we plan to establish some joint sessions at the bigger clinics to facilitate exchange of experience and advice: this will benefit both patients and therapists and is an important factor in a service which of necessity operates in some professional isolation.

On Speech Defects Dr. Hunt has this to say:—

"The two commonest defects were again considered to be dyslalia and stammering. Approximately 2% of school entrants have speech defects and it is usual for about half the children with defective articulation to show improvement without treatment during their first year at school. Children with a stammer seldom show this improvement, however."

The following table shows the work carried out at Speech Therapy Clinics in 1962:—

SPEECH THERAPY CLINICS—ANNUAL RETURNS OF WORK FOR 1962

Area and Officer	*No. of Clinics Operating*	*Cases discharged during year*	*Under Treatment at end of year*	*Under Observation*	*Awaiting Treatment*	*Totals*
E. Devon Miss Fisher	7	41	45	25	20	131
W. Devon Miss Chapman	7	45	45	15	23	128
N. Devon Miss Coleman	7	19	73	19	74	185
S. W. Devon Miss Blest (part-time)	5	26	23	—	20	69
Torbay Miss Monaghan Miss Hodginson (1-day)	7 1	30 11	45 13	46 25	30 7	151 56
Totals	34	172	244	130	174	720

CHILD GUIDANCE SERVICE

The service has not yet expanded as we had hoped, but slow progress is being made. Dr. Johnston continues to cover the Torbay and North Devon clinics, with Dr. Sime giving 2 sessions in addition in Torbay. Dr. Gaussen covers the East Devon area from the Exeter Clinic: unfortunately plans for the joint clinic with Exeter City at Heavitree Road have been held up but should be a reality in 1963. Children from south-west Devon are referred to the Plymouth Child Guidance Service, under Dr. Weeks.

Dr. Gaussen reports as follows:—

" The year finished with an increased waiting list of children to be seen, a greater number of children having been referred during 1962. This increase in numbers seems to be related to the shift in the pattern of illness in children. Physical illness is being treated successfully, and their general health is much improved but, along with this, there is an increasing concern with emotional disturbances and nervous disorders. Parents are better informed, and more aware of educational problems and of what should be provided for their children's difficulties.

The clinic has also helped in co-operating with helping the long-term graduate student placement. There has been much interest shown in child guidance methods by the county health visitors, who are really keen to discuss their cases.

I believe that as time goes on it will be realised to an ever-widening extent that the foundations of health are laid in childhood and that our communities are called upon to care for some of their members throughout their lives. Furthermore, prevention of mental ill-health is just as important as the prevention of bodily disease, and all those who are engaged in health-work have to take the widest possible view of the causation of illness. In child guidance we recognise the medical, educational and social factors responsible, but the small number of staff available will be quite unable to cope when once the public comes to see that the health of their children could be as much improved in the mental sphere as it has been in the physical.

The treatment of neurosis and behaviour disorders in children may be long and difficult, even when taken earlier than at present. In adults the treatment may be only palliative, the damage having been done. Mental hospitals are very costly and have to be very heavily staffed. More spent on research into the beginnings, the natural history, and the prevention of mental ill-health would be well invested. Prevention and education in their widest senses are the great need, rather than attempts to limit and isolate the disorders when fully developed. The total health of our society may seem an impossible ideal, but nothing less is called for if our children are to grow up to be mature adults.

In 1962, there was a great deal of interest in our work at the East Devon Child Guidance Clinic and we found that students,

social workers, teachers and others concerned with children are eager to learn and to exchange their points of view. Staff time is the limiting factor and, were more available, the educational and preventive side of our work could be carried much further. One child and his parents dealt with on the spot by teacher or health visitor could save that child a life-time of suffering and enable him to be a responsible citizen instead of a liability to society."

Dr. Johnston reports as follows:—

" The numbers of children and adolescents seen at both clinics, Barnstaple and Torquay, have increased steadily during the past year, more particularly at the latter.

It is gratifying that the staffing situation has become more stable since the appointment of psychologists and remedial teachers to both clinics on a more permanent basis. The result is that at both clinics, teams have been established to work together to the mutual benefit of all. The links established between clinics and schools through psychologists and remedial teachers have been invaluable in the handling of many problems. Indeed one feels that this is an essential part of any clinic set-up.

Conferences have continued with School Medical Officers and their respective staffs, and more are to be arranged. The problems raised have been interesting, and the discussions thereon have proved of value to all taking part."

CHILD GUIDANCE TREATMENT

Number of pupils treated at Child Guidance Clinics under arrangements made by the authority	652

CHILD GUIDANCE—ANNUAL RETURN, 1962

Total No. being treated 1st January, 1962	287
Residential	25
No. on Waiting List 1st January, 1962	35
No. referred during 1962	374
No. discharged during 1962	276
No. being treated 31st December, 1962	350
Residential	26
No. on Waiting List 31st December, 1962	69

School Meals Service

The Chief Education Officer has kindly provided the following information:—

" The number of kitchens operating at the end of 1962 was 298. This takes into account the closure of St. Giles-in-the-Wood, Petrockstowe, the Old School at Merton, together with the provision of kitchens at Kingsteignton Infants', Halwill County Primary and North Tawton County Primary which took over the County Secondary premises.

In addidtion there were kitchens attached to new schools at Merton, Crediton County Secondary and Torquay R.C. Cuthbert Mayne.

Extensive alterations were carried out to provide bigger kitchens at Exmouth Girls' County Secondary, Newton Abbot County Secondary, Tiverton Grammar, Bishopstawton County Primary, Shute County Primary and Thorverton C. of E. A new scullery in part of a temporary classroom was provided at Tiverton Elmore, where formerly the meals were taken in hired premises.

I append statistics in connection with the School Meals Service for 1962. This shows the comparison with 1961."

Comparative Statement—1961-1962

	Autumn 1961	*Autumn, 1962*
Maintained, Primary and Secondary Schools		
Meals		
Number present (day pupils only)	61,388	62,295
Number taking meals for full payment	37,703	40,060
Number taking meals for half payment ..	865	795
Number taking meals free	3,071	2,889
Total number taking meals	41,639	43,744
Percentage present taking meals	67.83%	70.22%
Milk		
Number present (including boarders) ..	61,750	62,605
Number drinking milk	47,574	48,288
Percentage present taking milk	77.04%	77.13%
Independent Schools		
Meals		
Schools supplied by School Meals Service	6	6
Number on Books	866	1,024
Number present	807	907
Number of meals supplied	244	303
Percentage present taking meals	30.24%	31.02%
Milk		
Schools supplied by Milk-in-Schools Scheme	125	113
Number present	11,128	9,710
Number drinking milk	9,415	8,459
Percentage present taking milk	84.61%	87.12%

PHYSICAL EDUCATION

The Chief Education Officer has also provided the following review which has been prepared by the Physical Education Organisers:—

Primary Schools

Physical Education has made steady progress during the year. Inevitably pupils in the schools without halls are at a disadvantage in wintry weather, but most teachers realise the need for some form of physical activity, however small the space in which to do it. Physical Education lessons cannot be effective unless co-ordinated with the general pattern of the school day. Cramped movements and ill-adjusted posture are little affected if after a period of work in the fresh air children return to sedentary work in unsuitable conditions in an overheated and overcrowded classroom. It is regrettable that this is the case in some schools, and even more regrettable that in some of our comparatively new schools the halls are having to be used as classrooms.

During the year refresher courses were held at ten different centres. Teachers were most co-operative, giving freely of their time to see demonstration classes showing new trends in the subject. Follow up work with the teachers after the courses is most difficult with only four organisers trying to cover the work in an area the size of Devon. The Primary P. E. Film made two years ago has been of great value to both teachers and children, and most schools have had the opportunity of seeing the film.

The greatest drawback to progress in the work is the lack of large climbing equipment, and this fact was mentioned in a number of Ministry of Education reports on schools. The money available for the purchase of large apparatus suitable for playgrounds or halls is quite inadequate and two schools only could be helped to buy large climbing frames.

The need to teach swimming at an early age is generally accepted by teachers, and more and more schools managed to get their own baths with the help of grants from the Education Committee. The smaller schools bought portable baths with plastic linings, but a few bigger schools built very fine concrete pools. Thirteen schools now have their own pools. The excellent results obtained during the short time which they have had these pools have shown their worth.

Dancing was taken in most schools as part of the P.E. programme in the summer. Wherever possible children dance out of doors as limited space hampers movement and so few schools have suitable floors for bare foot work.

Area Inter-School Sports Meetings were a feature of the summer programme. Most areas in the county ran extremely well organised Sports Meetings which were greatly enjoyed by the children.

Secondary Schools.

The staffing of schools with suitably qualified women teachers is still a problem and seems likely to remain so for some long time. Three men left us after a comparatively short time in Devon to teach in the Forces, but in general the position for boys is satisfactory

We provided a number of local refresher courses at which many teachers had opportunities of seeing lessons taken by their colleagues. These meetings gave them many new ideas and helped considerably to widen their experience. Some teachers attended national courses in Blackpool, Winchester and Loughborough and at Bisham Abbey. Demonstrations were given to the B.A.O.L.P.E. Conference in Devon, the Chartered Society of Physiotherapists, and on two occasions to students at St. Luke's College.

During the year Shelley School, Crediton, with a fully-equipped gymnasium, was opened. Five new gymnasia were planned and one of these will be equipped with a new type of tubular steel apparatus.

More schools have pupils taking the Duke of Edinburgh's Award and in particular many more took part in camping and expeditions than at any time in the past. For two weeks we used the Youth Service Camp at Thorverton and some fifty boys and girls camped there. A number of schools camped on Dartmoor and some did climbing and expeditions in Wales. All this was of great value in developing initiative, self-reliance and co-operation with others. Fourteen schools took part in the Ten Tors Expedition on Dartmoor.

Nine schools included Physical Education as a subject in the Devon Secondary Schools Examination. Their work included games, swimming, athletics, gymnastics and expeditions and generally some written work. The work in gymnastics in these schools showed a definite improvement.

Weather conditions for all the main athletics meetings were good. The County Teams did well in the South Western Counties meeting in Sherborne, and in the National Championships in July Devon gained five 2nds, three 3rds, two 4ths, one 5th, three 6ths and thirteen standard medals.

The Schools County Netball Team was unbeaten, having played Somerset, Bristol, Cornwall and Plymouth.

After many school and inter-area games, a good County Cricket Team was selected. Though not as strong as the 1961 team it beat Cornwall, drew with Somerset and lost to Bristol.

A number of non-turf wickets were constructed, but there is still a great shortage of practice wickets and very few schools have good match wickets either. It is hoped that the advice of the newly-appointed Playing Fields Officer will help to remedy this situation.

As in primary schools, the Committee has done much with grants to encourage schools to build swimming baths. Five new concrete baths came into use during the year and one large portable

pool. An interesting experiment took place in the solar heating of one bath, but the results were not very encouraging because of the lack of sunshine last summer. As last year we have had the National Swimming Coach in Devon and have had demonstrations for teachers at seven centres.

During the year primary and secondary school pupils were tested for County Swimming Awards and comparative figures over three years are:—

	1962	1961	1960
Beginners	2432	2482	2440
Proficiency	487	622	527
Star Proficiency	110	138	130

The South Devon Schools Sailing Association continued to flourish. During the year a survey was made for the Consumers' Association on suitable life jackets, and schools gained much useful information on personal buoyancy. A Sailing Course for Teachers and Youth Leaders was arranged in Plymouth in conjunction with the C.C.P.R. and the Plymouth Education Committee. Schools continued to use as their main craft the G.P.14 dinghy. It is a most versatile craft and when a fleet of these is available large scale inter-school regattas will be arranged.

M. M. CHETHAM
A. A. BROWN

STATISTICS

Population

The numbers of children on the school registers are as follows:—

Primary Schools	39,469
Secondary Schools	17,118
Grammar Schools	8,831
Comprehensive Schools	1,711
Special Schools	291
	67,419

STAFF OF THE MEDICAL DEPARTMENT. Appendix I.

County Medical Officer and Principal School Medical Officer.
W. J. Doyle, M.B., B.Ch., B.A.O., D.P.H., B.Sc., L.M.

Deputy County Medical Officer and Deputy Principal School Medical Officer.
D. E. Cullington, M.A., M.B., B.Chir., D.C.H., D.P.H.

Senior Medical Officer for Maternal and Infant Health.
F. Gloria Richards, M.R.C.S., L.R.C.P., D.(Obst.) R.C.O.G.

Senior Medical Officer for Child Health.
I. Madeleine Pinkerton, M.B., B.Ch., D.P.H. (resigned 28.2.62)
A. D. Lepine, M.R.C.S., L.R.C.P., D.P.H. (from 1.5.62).

Senior Medical Officer for Adult Health
D. S. Parken, M.B., B.S., M.R.C.S., L.R.C.P., D.C.H., D.P.H.

Senior County Dental Officer and Principal School Dental Officer.
J. D. Sykes, L.D.S.

County Superintendent of Nursing and Supervisor of Midwives.
Miss G. Heather, S.R.N., S.C.M., H.V.C.

Superintendent Health Visitor.
Miss E. L. Hunter, S.R.N., C.M.B. (Pt.I.), H.V.C.

Health Education Officer: Miss P. O. Davies, R.M., D.H.Ed.

County Health Inspector: M. S. Powling, C.R.S.I., M.S.I.A.

Lay Administrative Officer: J. Cooke

Chief Clerk: H. T. Baldwyn.

County Ambulance Officer: R. P. Selley, D.P.A., F.I.A.O.

Home Help Organiser: G. P. Brooks, D.P.A., D.S.A.

Senior Social Worker in Mental Health: L. H. Jenkins, D.S.S., M.H. Cert.

Senior Occupational Therapist, Miss M. M. Keily, M.A.O.T.

Medical Officers

L. G. Anderson, M.D., Ch.B., D.P.H.
H. M. Davies, M.A., M.R.C.S., L.R.C.P., D.P.H.
F. T. Hunt, M.B., B.S., M.R.C.S., L.R.C.P., D.P.H., D.I.H.
R. C. MacLeod, M.D., D.P.H., D.T.M.&H.
D. K. MacTaggart, M.A., M.B., Ch.B., D.P.H.
R. B. Walker, M.R.C.S., L.R.C.P., D.P.H.
J. H. Wildman, M.R.C.S., L.R.C.P., D.P.H.
E. Williams, M.R.C.S., L.R.C.P., D.P.H.

(Mixed Appointments)

N. E. R. Archer, M.A., D.M., B.Ch., D.P.H.
M. E. Budding, B.Sc., M.B., B.Ch., D.P.H.
L. Solomon, B.A., M.B., B.Ch., B.A.O., L.M., D.P.H., D.C.H.
R. H. Browning, M.B., B.S.
W. E. Denbow, B.Sc., M.R.C.S., L.R.C.P., D.P.H.
M. J. Dunn, M.B., Ch.B.
D. M. Green, M.B., B.S., M.R.C.S., L.R.C.P., D.P.H.
J. M. Hinde, M.A., B.M., B.Ch., D.R.C.O.G. (resigned 31.5.62)
P. W. Tait, M.B., Ch.B.Ed. (from 1.11.62)
W. Burgess, M.R.C.S., L.R.C.P., M.B., B.S., D.C.H., M.R.C.P., M.D. (part-time)
S. C. Candler, M.B., Ch.B., M.R.C.S., L.R.C.P. (Part-time)
M. R. Epstein, L.R.C.P.I. & L.M., D.C.H., R.C.S.I. (part-time)
M. C. H. Kingdon, M.B.E., M.A., M.B., B.Ch., M.R.C.S., L.R.C.P. (part-time).
J. M. MacTaggart, M.B., Ch.B., D.P.H. (part-time).

School Ophthalmic Surgeons. *

R. C. Chaturvedi, M.B., B.S., D.O.
A. J. A. McCormick, M.B., Ch.B., F.R.C.S., D.O.M.S.

Chest Physicians. *

G. E. Adkins, M.B., B.Chir. (Cantab.)
W. E. B. Lloyd, M.R.C.S., L.R.C.P., D.P.H.
J. C. Mellor, M.B., B.Ch.

Psychiatrists—Child Guidance *

H. S. Gaussen, M.R.C.S., L.R.C.P.
W. Johnston, M.B., Ch.B., D.P.M.
D. A. Sime, M.B., Ch.B.Ed.

* *(on staff of the Regional Hospital Board)*

Dental Officers

I. Blake, L.D.S., R.C.S.
G. H. S. Clarke, L.D.S.
G. J. Derbyshire, L.D.S.
J. L. Dickson, L.D.S., R.F.P.S.
H. W. Gibbs, L.D.S., R.C.S.
A. S. Peacock, L.D.S., D.D.O. (also part-time Orthodontist).
F. A. Pearse, L.D.S.
C. T. Pomeroy, L.D.S., R.C.S.
Barbara J. Shapland, L.D.S.
J. Smith, L.D.S.
J. E. B. Smith, L.D.S., R.C.S. (resigned 1.3.62)
J. W. Steer, L.D.S., R.C.S.
E. R. Trythall, L.D.S.
J. K. Vowles, B.D.S.
F. M. Warren, B.D.S., L.D.S., R.C.S.
F. R. P. Williams, C.B.E., B.D.S., F.D.S.
T. B. H. Wood, B.D.S. (9.4.62 to 9.6.62)
Pamela W. Goodman, L.D.S. (part-time from 13.11.62)
V. G. Holdsworth, L.D.S., R.C.S., (part-time)
Margaret McKee, L.D.S., R.C.S. (part-time from 26.9.62 to 23.11.62)
W. H. Shapland, L.D.S., R.C.S. (part-time)
Elspeth J. Turner, L.D.S., R.C.S. (part-time to 14.2.62)
M. V. C. West, L.D.S., (part-time) to 28.5.62

Dental Auxiliary

Ruth Stephens (from 10.9.62)

Oral Hygienist

Jill Pattison (from 24.9.62)

MEDICAL OFFICERS OF HEALTH

Area	*District Councils*		*Medical Officers of Health*
1	B. Salterton	U.D.	L. G. Anderson, M.D., D.P.H.
	Exmouth	U.D.	
	St. Thomas	R.D.	
2	Ottery St. Mary	U.D.	R. C. MacLeod, M.D., D.P.H., D.T.M. & H.
	Sidmouth	U.D.	
	Honiton	M.B.	
	Seaton	U.D.	
	Axminster	R.D.	
	Honiton	R.D.	
3	Crediton	U.D.	N. F. Sawers, M.B., Ch.B.
	Crediton	R.D.	L. N. Jackson, B.A., D.M.
	Tiverton	M.B.	G. Nicholson, M.D., D.P.H., F.R.C.S.
	Tiverton	R.D.	
4	Barnstaple	M.B.	E. Williams, M.R.C.S., L.R.C.P., D.P.H.
	Barnstaple	R.D.	
	South Molton	M.B.	
	South Molton	R.D.	
	Ilfracombe	U.D.	A. H. Morley, O.B.E., M.B., Ch.B., F.R.C.S., D.P.H.
	Lynton	U.D.	M. P. Nightingale, M.R.C.S., L.R.C.P.
5	Gt. Torrington	M.B.	C. F. R. Briggs, M.B., B.S., M.R.C.S., L.R.C.P.
	Bideford	R.D.	N. B. Betts, M.B., B.Chir., F.R.C.S., L.R.C.P.
	Torrington	R.D.	H. Mervyn Thomas, M.B., Ch.B., D.P.H., D.C.H.
	Northam	U.D.	
	Bideford	M.B.	
	Holsworthy	U.D.	
	Holsworthy	R.D.	
6	Okehampton	M.B.	E. D. Allen-Price, M.D., D.P.H.
	Tavistock	U.D.	
	Broadwoodwidger	R.D.	
	Okehampton	R.D.	
	Tavistock	R.D.	
7	Salcombe	U.D.	R. B. Walker, M.R.C.S., L.R.C.P., D.P.H.
	Kingsbridge	U.D.	
	Kingsbridge	R.D.	
	Plympton St. Mary	R.D.	

MEDICAL OFFICERS OF HEALTH—*continued*

Area	*District Councils*		*Medical Officers of Health*
8	Dawlish	U.D.	H. M. Davies, M.A., M.R.C.S., L.R.C.P., D.P.H.
	Newton Abbot	U.D.	
	Teignmouth	U.D.	
	Newton Abbot	R.D.	
9	Torquay	M.B.	D. K. MacTaggart, M.A., M.B., Ch.B., D.P.H.
10	Totnes	M.B.	F. T. Hunt, M.B., B.S., M.R.C.S., L.R.C.P., D.P.H., D.C.H.,
	Ashburton	U.D.	
	Buckfastleigh	U.D.	
	Totnes	R.D.	
11	Dartmouth	M.B.	J. H. Wildman, M.R.C.S., L.R.C.P., D.P.H.,
	Brixham	U.D.	
	Paignton	U.D.	

TABLE I

TUBERCULOSIS **Occupation of notified cases.**

Socio-Economic Group	*Notifications*		
	Pulmonary	*Non-Pulmonary*	*Total*
A. AGRICULTURAL			
1. Farm Workers	1	1	2
2. Farm employers and managers	—	—	—
3. Own Account	1	—	1
B. NON-AGRICULTURAL			
I. *Non.-Manual*			
1. Employers & Managers (Large Firms)	1	—	1
2. Intermediate non-manual (including Supervisors, teachers etc.	7	2	9
3. Employers & Managers (small firms under 25)	4	3	7
4. Clerical Workers } Junior	7	2	9
5. Shop Assistants } non-manual	4	1	5
6. Personal Service	6	—	6
A. 5. Professional self-employed	—	—	—
6. Professional employers	—	—	—
B. II. *Manual*			
1. Foremen	—	1	1
2. Skilled workers	12	1	13
3. Semi-skilled	4	—	4
4. Unskilled	5	—	5
5. Own account working (non-professional) and no employees	—	—	—
C. SPECIAL GROUP			
1. Armed Forces (O.Rs.)	2	—	2
2. Housewives	23	15	38
3. Retired Persons	12	1	13
4. Children	8	4	12
5. Institutions	2	—	2
6. Others	2	—	2
No information available	14	10	24

TABLE II

Clinical Classification.

		Pul.	*Non-Pul.*
A. T.B. Negative	(1) Slight constitutional disturbance	23	6
	(2) All cases not (1) or (3)	12	1
	(3) Profound systemic disturbance	3	—
B. T.B. Positive	(1) Slight constitutional disturbance	26	13
	(2) All cases not (1) or (3)	18	3
	(3) Profound systemic disturbance	10	—
	Information not available	23	18

TABLE III

MASS RADIOGRAPHY SERVICE

Report on work carried out in the County of Devon during the year ended 31st December, 1962.

	Male	*Female*	*Total*
Number of Devon County Residents examined	22,113	17,848	39,961

INCIDENCE OF DISEASE

A. *Pulmonary tuberculosis*

1. Newly discovered significant cases

		Per thous.
(a) Requiring treatment ..	33	.82
(b) Requiring observation ..	46	1.1

2. No further action 221

3. Previously known .. 56

B. *Other Conditions.*

Pneumonitis	34
Bronchiectasis	31
Bronchitis and emphysema ..	63
Asthma	2
Sarcoidosis	6
Carcinoma of bronchus	18
Pneumoconiosis	5
Pulmonary metastasis	2
Other tumours	
Thyroid enlargement ..	31
Cardiovascular disease ..	
Congenital	10
Acquired	101
Diaphragmatic abnormality ..	22
Hiatus hernia	5
Bony abnormality	144
Azygos lobe	13
Pleuropericardial cyst	2
Pulmonary fibrosis	8
Old empyema	1
Pleural reaction	1
Lung abscess	1
Fibrous scarring	1
Pleural thickening	42
Tracheal malaria	1
Paget's disease	2

AGE AND SEX ANALYSIS OF NEWLY-DISCOVERED SIGNIFICANT CASES OF ACTIVE PULMONARY TUBERCULOSIS REQUIRING TREATMENT

(Group A1(a) above)

	—15	15—24	25—34	35—44	45—59	60+	Total
Male	—	1	1	3	10	2	17
Female	1	4	6	2	2	1	16
Total	1	5	7	5	12	3	33

DEVON

GROUP SURVEY ANALYSIS

Group	*Number Examined*			*Tuberculosis requiring treatment*		
	Male	*Female*	*Total*	*Male*	*Female*	*Total*
Servicemen	574	—	574	1	—	1
General Practitioner referrals	189	184	373	—	—	—
School leavers	1271	1017	2,288	—	—	—
Tuberculin positive children	709	635	1,344	—	1	1
Contacts	163	157	320	—	—	—
Contacts of tuberculin positive children	347	484	831	3	1	4
Special occupational surveys	335	2	337	—	—	—
Small firms and appointments	5,302	2,846	8,148	3	3	6
Large firms	3,441	895	4,336	—	—	—
Students	214	96	310	—	—	—
General Hospital staff	233	740	973	—	1	1
School staff	527	965	1,492	—	2	2
Prisons	906	355	1,261	1	1	2
Public	6,210	7,984	14,194	8	5	13
Ante-natal patients	—	123	123	—	—	—
Mental Hospital staff	318	217	535	1	—	1
Mental hospital patients	1,374	1,148	2,522	—	2	2
TOTAL	22,113	17,848	39,961	17	16	33

TABLE IV

CHEST HOSPITALS. DISEASE CLASSIFICATION ON ADMISSION

	Classification	Hawkmoor				Hawley			
		Males	*Females*	*Children*	*Total*	*Males*	*Females*	*Children*	*Total*
	Non-Tuberculous Thoracic Surgical	283	160	40	483	—	—	—	—
	Medical Non-Tuberculous	301	110	19	430	1	3	—	4
Pulmonary	Class R.A.1.	1	5	2	8	2	3	—	5
	,, R.A.2.	2	—	—	2	—	—	—	—
	,, R.A.3.	—	—	—	—	—	—	—	—
	,, R.B.1.	14	16	—	30	3	3	—	6
	,, R.B.2.	8	9	—	17	11	1	—	12
	,, R.B.3.	21	6	—	27	1	—	—	1
Non-Pulmonary	Class N.R.A.	1	—	—	1	1	3	—	4
	,, N.R.B.	2	3	—	5	1	1	—	2
	TOTAL	633	309	61	1003	20	14	—	34

Abbreviations: R.A. —tuberculosis negative (pulmonary)
R.B. —tuberculosis positive (pulmonary)
N.R.A.—tuberculosis negative (non-pulmonary)
N.R.B.—tuberculosis positive (non-pulmonary)
Numbers—stages of disease

TABLE V

The following Table gives the birth weight, place of birth, and the number of premature babies surviving in each group at the end of 28 days.

Weight at Birth	Premature Live Births. Total Notified 395.															Premature Still-Births		
	Born in Hospital			*Born at Home and Nursed entirely at Home*			*Born at Home and transferred to hospital on or before 28th day*			*Born in Nursing Home and nursed entirely there*			*Born in Nursing Home and transferred to hospital on or before 28th day*			Total Notified 44		
	Total	*Died within 24 hrs. of birth*	*Survived 28 days*	*Total*	*Died within 24 hrs. of birth*	*Survived 28 days*	*Total*	*Died within 24 hrs. of birth*	*Survived 28 days*	*Total*	*Died within 24 hrs. of birth*	*Survived 28 days*	*Total*	*Died within 24 hrs. of birth*	*Survived 28 days*	*Born in Hospital*	*Born at Home*	*Born in Nursing Home*
3lb. 4oz. or less	38	15	17	—	—	—	2	2	—	—	—	—	—	—	—	18	—	—
Over 3lb. 4ozs. up to and including 4lb. 6ozs.	61	4	54	5	—	5	5	1	4	—	—	—	—	—	—	11	3	—
Over 4lb. 6oz. up to and including 4lb. 15oz.	75	4	66	10	—	10	2	—	1	—	—	—	1	—	—	7	—	—
Over 4lb. 15oz up to and including 5lb. 8oz.	139	4	132	52	—	52	1	1	—	4	—	4	—	—	—	5	—	—
Totals	313	27	269	67	—	67	10	4	5	4	—	4	1	—	—	41	3	—

TABLE VI.

REGISTERED BLIND AND PARTIALLY SIGHTED PERSONS

	CAUSES OF DISABILITY					
(i) Number of cases registered during the year in respect of which, in Form B.D.8, Section F(1 & 2) recommends:	*Cataract*	*Glaucoma*	*Cataract and Glaucoma*	*Senile Macular Degeneration*	*Others*	*Total registered during year*
BLIND (a) No treatment	15	3	3	10	26	
(b) Treatment or re-examination	14 (see Note A)	7	10 (see Note B)	5 (See Note C)	26 (see Note D)	
TOTALS	29	10	13	15	52	119
PARTIALLY SIGHTED (a) no treatment	2	—	1	—	4	
(b) Treatment or re-examination	27 (See Note E)	2	6 (see Note F)	5 (See Note G)	11 (See Note H)	
TOTALS	29	2	7	5	15	58
(ii) Number of cases at (i) (b) above which on follow-up action have received treatment:—						
BLIND	5	7	7	4	22	
PARTIALLY SIGHTED	15	2	4	2	8	

NOTES:—A. In two of these cases operations were recommended, but were refused by the blind person. In three other cases the general physical condition prevented operation. Four cases are pending.

B. In one case the patient refuses operation, and in two cases treatment is pending.

C. In one case the blind person died before treatment could be given.

D. In one of these cases the blind person died before treatment could be given. Three cases are pending.

E. In nine cases treatment is pending. One person refuses operation, one person left the county before treatment, and in one case the general physical condition prevents treatment.

F. One case is pending, and in one case the person died before treatment could be given.

G. One person left the county before treatment could be given, and two cases are pending.

H. Three cases are pending.

TABLE VII

SCHOOL MEDICAL INSPECTION

—PERIODIC MEDICAL INSPECTIONS

Age Groups Inspected (By year of birth)	*No. of Pupils inspected*	*Physical Condition of Pupils Inspected*			
		Satisfactory		*Unsatisfactory*	
		No.	% of Col. 2	*No.*	% of Col. 2
(1)	(2)	(3)	(4)	(5)	(6)
1958 and later	103	103	100.0	—	—
1957	3,597	3,591	99.8	6	0.2
1956	2,301	2,299	99.9	2	0.1
1955	534	532	99.6	2	0.4
1954	2,298	2,296	99.9	2	0.1
1953	2,292	2,285	99.7	7	0.3
1952	882	879	99.7	3	0.3
1951	1,014	1,007	99.4	7	0.6
1950	2,394	2,383	99.5	11	0.5
1949	1,678	1,672	99.6	6	0.4
1948	1,393	1,387	99.6	6	0.4
1947 and earlier	4,297	4,291	99.9	6	0.1
TOTALS	22,783	22,725	99.75	58	0.25

—OTHER INSPECTIONS

Number of Special Inspections	257
Number of Re-inspections	3,779
TOTAL ..	4,036

—PUPILS FOUND TO REQUIRE TREATMENT AT PERIODIC MEDICAL INSPECTIONS

(excluding Dental Diseases and Infestation with Vermin)

Notes:—Pupils found at Periodic Inspections to require treatment for a defect are not excluded from Table C by reason of the fact that they were already under treatment for that defect. Table C relates to individual pupils and not to defects. Consequently, the total in column (4) will not necessarily be the same as the sum of columns (2) and (3).

Age Groups Inspected (By year of birth)	*For defective vision (excluding squint)*	*For any of the other conditions recorded in Part II*	*Total individual pupils*
(1)	(2)	(3)	(4)
1958 and later	—	24	15
1957	31	206	187
1956	34	189	166
1955	5	48	31
1954	51	155	168
1953	63	215	196
1952	30	67	68
1951	28	85	81
1950	93	152	191
1949	74	120	145
1948	52	142	120
1947 and earlier	223	360	435
TOTALS	684	1,763	1,803

Table VIII

—RETURN OF DEFECTS FOUND BY MEDICAL INSPECTION IN THE YEAR ENDED 31st DECEMBER, 1962.

NOTE:—All defects noted at medical inspection as requiring treatment are included in this return, *whether or not this treatment was begun before the date of the inspection.*

Defect Code No.	*Defect or Disease*	Periodic Inspections		Special Inspections	
		No. of defects		*No. of defects*	
		Requiring treatment	*Requiring to be kept under observation but not requiring treatment.*	*Requiring treatment*	*Requiring to be kept under observation but not requiring treatment.*
	(1)	(2)	(3)	(4)	(5)
4	Skin	260	455	13	3
5	Eyes—*a.* Vision ..	684	552	19	9
	b. Squint ..	150	187	9	3
	c. Other ..	92	132	4	6
6	Ears—*a.* Hearing ..	64	440	8	7
	b. Otitis Media	33	338	5	6
	c. Other ..	12	50	—	—
7	Nose or Throat ..	188	1,548	3	21
8	Speech	83	440	5	11
9	Lymphatic Glands ..	17	757	—	8
10	Heart	18	264	2	3
11	Lungs	91	450	26	9
12	Developmental—				
	a. Hernia ..	13	53		—
	b. Other ..	45	276	1	6
13	Orthopaedic—				
	a. Posture ..	50	380	3	9
	b. Feet ..	182	482	2	5
	c. Other ..	184	580	8	7
14	Nervous system—				
	a. Epilepsy ..	24	44	1	2
	b. Other ..	37	164	2	3
15	Psychological—				
	a. Development	81	312	52	6
	b. Stability ..	95	444	53	8
16	Abdomen	18	77	1	1
17	Other	13	174	—	4

Table IX

INFESTATION WITH VERMIN

(i)	Total number of examinations in the schools by the school nurses or other authorized persons	121,382
(ii)	Total number of *individual* pupils found to be infested ..	263
(iii)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54 (2), Education Act, 1944) ..	65
(iv)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54 (3), Education Act, 1944) ..	1

TABLE X

FOURTH YEAR OF SOUTH DEVON HEARING ASSESSMENTS SCHEME 1962

1. School Population of Area = 23,000 approx.
   Pre-school .. .. = 11,000 ,,

	Referred in 1962	*Incomplete cases brought forward from previous years.*	*Total*
2. No. of children referred for investigation ..	105	170	275
3. Children were referred by:—			
School M.O.		80	8 Pre-school
Health Visitor or Nursing Assistant		42	3 ,,
E.N.T. Surgeon (Mr. Bradbeer)		38	11 ,,
Child Guidance Service		4	1 ,,
G.P.		4	
Head Teacher		1	
Audiology Unit (London)		1	
		170	
4. Of the cases referred:—			
Investigation completed	48	57	105
Investigation incomplete	39	99	138
Investigation not yet started	4	8	12
Investigation referred by parents	5	2	7
Left area before completion	9	4	13
	105	170	275
5. Children seen at *Hearing Clinic*			
No further action needed	22	4	26
For re-check	53	65	118
Referred to Hospital Assessment Clinic ..	18	58	76
	93	127	220

Number of Sessions 69
Total No. of examinations 272
42 school children
27 pre-school children
220 school children
52 pre-school children

6. Children referred to Hospital Assessment Clinic following Audiometry and known history ..	3	11	14
7. *Hospital Assessment Clinic*			
No further action advised	4	4	8
Advised operative treatment	3	8	(6 pre- 11
Advised Hearing Aid (or one already issued)	8	21	school) 29
Advised Operation and Hearing Aid ..	3	0	3
Further observation	10	21	31
Parents refused assessment	3	2	5
	31	56	87

No. of Sessions 25 (17 school children 8 pre-school).
Total No. of Examinations 190

TABLE XI

EAST DEVON HEARING ASSESSMENT

Sessions	21
Appointments given	92
Appointments kept	87
Old Patients Attendances	37
New Patient Attendances	50

No hearing loss found—discharged	13
For continued observation in School or Child Welfare Clinic	12
Further investigation or supervision at Clinic	25
Referred elsewhere for Treatment— To General Practitioner— otorrhoea	6
Consultants—removal of tonsils and adenoids	5
Plastic surgery to auricle	1
Speech Therapy	5
Using Hearing aids	15
Prescribed Hearing Aid in 1962	5
Left School—continued supervision arranged	1
Left the County—information passed to present Local Authority	2

Comparison with previous years

	1962	1961 (incomplete)	1960
Sessions	21	10	22
Appointments given	92	57	106
Appointments kept	87	48	64
New Patients	50	32	36
No hearing loss found	13	11	11
Hearing aids prescribed	5	5	4
Hearing aids in use (end of year)	15	11	6

TABLE XII.

DENTAL INSPECTION AND TREATMENT CARRIED OUT BY THE AUTHORITY.

(1)	Number of pupils inspected by the Authority's Dental Officers:		
	(*a*) At Periodic Inspections		45,456
	(*b*) At Specials		2,761
		Total (1) ..	48,217
(2)	Number found to require treatment		25,048
(3)	Number offered treatment		18,541
(4)	Number actually treated		12,981
(5)	Attendances made by pupils for treatment (including 11(*h*) below)		38,373
(6)	Half-days devoted to: Periodic (School) Inspection	..	741
	and Treatment (incl. Orthodontics)	..	6,334
		Total (6) ..	7.075
(7)	Fillings: Permanent Teeth		23,979
	Temporary Teeth		7,132
		Total (7) ..	31,111
(8)	Number of teeth filled: Permanent Teeth		20,153
	Temporary Teeth		6,386
		Total (8) ..	26,539
(9)	Extractions: Permanent Teeth		2,936
	Temporary Teeth		7,509
		Total (9) ..	10,445
(10)	Administration of general anaesthetics for extraction.. ..		2,213
(11)	Orthodontics :		
	(*a*) Cases commenced during the year		400
	(*b*) Cases carried forward from previous year		560
	(*c*) Cases completed during the year		281
	(*d*) Cases discontinued during the year		135
	(*e*) Pupils treated with appliances		498
	(*f*) Removable appliances fitted		462
	(*g*) Fixed appliances fitted		11
	(*h*) Total attendances..		5,517
(12)	Number of pupils supplied with artificial dentures		76
(13)	Other operations: Permanent Teeth		15,652
	Temporary Teeth		3,427
		Total (13) ..	19,079

TABLE XIII

IMPROVEMENTS TO OFFICES, SANITATION, ETC., CARRIED OUT DURING YEAR ENDED 31st DECEMBER, 1962

County Primary Schools:	
Alphington	Additional lavatories for Infants.
Ashburton	Rebuilding and improvements to lavatories
Barnstaple: Sticklepath	Improvements to Offices; additional basins.
Broadhempston	Provision of Staff lavatory
Clyst Hydon	Additional washing facilities and hot water supply.
Copplestone	Additional W.C.'s
Dartmouth	Improvements to Offices.
Dawlish Infants	Hot water supply; additional basins, and improvements to lavatories.
Denbury	Staff lavatories and cloakroom.
Filleigh	Mains water supply
Horrabridge	Staff cloakroom and Toilet.
Huccombe	Additional wash basins and hot water supplies.
Ide	Additional cloakroom and basins.
Kentisbury	Mains water supply.
Lapford	Additional basins and hot water supply.
Milton Abbot	Improvements to Boys' Offices.
Paignton: Oldway	Additional wash basins.
Plymstock: Goosewell	Provision of indoor Toilets.
Shebbear	Additional basins and hot water supplies.
Tiverton: Cowleymoor	Provision of Staff Toilets.
West and East Putford	Additional basins and hot water supplies.
Voluntary Primary Schools:	
Dittisham	Staff cloakroom and lavatories.
Holywell	Provision of new Offices Block.
Malborough	Provision of new Offices Block.
Plympton St. Mary	Improvements to washing facilities.
Torquay: Ilsham	Improvements to lavatories.
Grammar Schools:	
Newton Abbot	Additional cloakroom wash basins.
Teignmouth	Provision of Staff lavatories.
County Secondary School:	
Okehampton	Additional lavatories and basins.
Further Education	
Newton Abbot Technical Institute	Additional lavatories.
Clinics	
Barnstaple: Alexandra Road	Additional lavatories

Hot Water Supplies to Wash Basins have been provided at the following:

County Primary School:

Ashwater
Braunton
Broadhempston
Broadwoodwidger
Christow
Clyst St. Mary
Dunsford
Hatherleigh
Highampton
Holbeton
Milton Damerel
Ottery St. Mary: Westhill
Shirwell
Spreyton
Stokenham
Throwleigh
Ugborough
Whitchurch

Voluntary Primary School:

Blackpool
Lamerton
Northlew
Poughill
Uplowman
Yarcombe

County Secondary School: Barnstaple Boys'

TABLE XIV—HANDICAPPED PUPILS REQUIRING EDUCATION AT SPECIAL SCHOOLS

During the calendar year ended 31st December, 1962	(1) *Blind* (2) *Partially sighted* (1)	(2)	(3) *Deaf* (4) *Partially deaf* (3)	(4)	(5) *Physically Handicapped* (6) *Delicate* (5)	(6)	(7) *Maladjusted* (8) *E.S.N.* (7)	(8)	(9) *Epileptic* (10) *Speech Defects* (9)	(10)	*Total Cols.* 1-10 (11)
A. How many handicapped pupils were newly assessed as needing special educational treatment at special schools or in boarding homes?		1	—	2	18	24	14	118	—	—	177
B. (i) of the children included at A, how many were newly placed in special schools (other than hospital special schools) or boarding homes?		1	—	—	10	7	6	12	1	—	37
(ii) of the children assessed prior to 1st January, 1962, how many were newly placed in special schools (other than hospital special schools) or boarding homes?	2	3	—	2	12	1	2	30	—	—	52
Total (B(i) and B (ii))	2	4	—	2	22	8	8	42	1	—	89
On or about 20th January, 1963, how many handicapped pupils from the Authority's area											
C. (i) were requiring places in special schools—TOTAL (a) day	—	—	—	—	2	1	—	2	—	—	5
(b) boarding	2	—	—	—	7	4	2	237	—	—	252
(ii) included at (i) had not reached the age of 5 and were awaiting (a) day places	—	—	—	—	2	—	—	—	—	—	2
(b) boarding places	1	—	—	—	—	—	—	—	—	—	1
(iii) included at (i) who had reached the age of 5, but whose parents had refused consent to their admission to a special school, were awaiting— (a) day places	—	—	—	—	—	—	—	—	—	—	—
(b) boarding places	—	—	—	—	—	2	—	120	—	—	122
D. (i) were on the registers of (1) maintained special schools as (a) day pupils	—	—	—	6	45	28	—	6	—	—	85
(b) boarding pupils	—	2	—	—	1	—	1	190	—	—	194
(2) non-maintained special schools as (a) day pupils	—	4	1	6	1	—	—	—	—	—	12
(b) boarding pupils	15	14	15	8	29	2	3	3	5	—	94
TOTAL	15	20	16	20	76	30	4	199	5	—	385
(ii) were on the registers of independent schools under arrangements made by the Authority	—	—	—	1	12	15	7	7	—	—	42
TOTAL (D (i) and D (ii))	15	20	16	21	88	45	11	206	5	—	427
(iii) were boarded in homes and not already included under (i) and (ii) above	—	—	—	—	—	1	18	—	—	—	19
TOTAL (D (i), (ii) and (iii))	15	20	16	21	88	46	29	206	5	—	446
E. On or about 20th January, 1963, how many handicapped pupils (irrespcetive of the areas to which they belong) were being educated under arrangements made by the Authority in accordance with Section 56 of the Education Act, 1944											
(i) in hospitals	—	—	—	—	—	9	—	—	—	—	9
(ii) in other groups (e.g. units for spastics, convalescent homes)	—	—	—	—	—	13	—	—	—	—	13
(iii) at home	1	—	—	—	6	9	2	7	—	—	25

TABLE XV

SCHOOL CLINICS

Town	*Address*	*Phone No.*	*Type of Clinic*	½-day Sessions		
				Week	*Fort-night*	*Month*
Appledore ..	Appledore Hall		Minor Ailment			1
Ashburton ..	Council School		Minor Ailment	1		
Axminster ..	Secondary Modern School	2146	Minor Ailment	1		
	,, ,, ,,		Dental	1		
	Plaza Cinema	2123	Vision			½
	Secondary Modern School		Speech	1		
Barnstaple ..	19 (b) Alex. Road ..	3549	Minor Ailment	5		
	,, ,, ..		Dental (whole-time) ..		21	
	,, ,, ...		Speech	3		
	,, ,, ...		Vision			1½
	19 (c) ,, ...		Child Guidance ..	2		
	Forches Cross		Speech	2		
Bideford ..	Coronation Road ..	1121	Minor Ailment	1		
	,, ,, ..		Dental (part-time) ..	4		
	,, ,, ..		Speech	2		
	,, ,, ..		Vision			1
	C. of E. Institute . ..		Minor Ailment	1		
Braunton ..	Parish Hall		Minor Ailment	1		
Brixham ..	Greenswood Road	3374	Minor Ailment	1		
	,, ,, ..		Vision			1
	,, ,, ..		Dental	1		
	,, ,, ..		Speech	1		
Buckfastleigh	Council School	3104	Minor Ailment			3
Budleigh Salterton	Church Institute		Minor Ailment		1	
Chudleigh ..	Pitt House Junior ..		Speech	1		
Colyton ..	Youth Club, High Street		Minor Ailment		1	
Combe Martin	Town Hall		Minor Ailment		1	
Crediton ..	Newcombes	2649	Minor Ailment ..	1		
	,, ,, ...		Dental (part-time) ..	4		
	,, ,, ...		Speech	2		
	,, ,, ...		Vision			½
Cullompton ..	County Primary School		Speech		1	
Dartmouth ..	Mayors Avenue	245	Minor Ailment	1		
	,, ,, ...		Dental ..		1	
	,, ,, ...		Speech	1		
	,, ,, ...		Vision			1
Dawlish ..	The Knowle, Barton Road	3254	Minor Ailment		1	
	,, ,, ,, ,,		Vision			½
	,, ,, ,, ,,		Speech		1	
Exeter ..	Alice Vlieland Centre ..	54685	Dental (part-time Orthodontic) ..		1	
	,, ,, ,, ..		Vision			1
	,, ,, ,, ..		Hearing Assess ..			2
	Royal Devon & Exeter Hospital	72261 & 59261	Dental (part-time) ..		1	
	49 Polsloe Road ..		Child Guidance ..	4		
	,, ,, ..		Speech	2		
	City Hospital		Speech	2		
Exmouth ..	St. Clements, 142 Exeter Road	2610	Minor Ailment	3		
	,, ,, ,, ..		Dental (part-time) ..	7		
	,, ,, ,, ..		Speech	2		
	,, ,, ,, ..		Vision			½
	,, ,, ,, ..		Orthodontics			1
	Withycombe House ..		Speech	1		
Fremington ..	Parish Church Hall ..		Minor Ailments			1
	C.P. School		Speech	1		

Town	Address	Phone No.	Type of Clinic	½-day Sessions Week	Fort-night	Month
Holsworthy ..	Town Hall		Minor Ailment			1
	.. ,,		Vision			1
	Secondary Modern School	30	Speech	1		
Honiton ..	The Clinic	283	Minor Ailment	1		
	,, ,,		Dental	1		
	,, ,,		Vision			½
	,, ,,		Speech		1	
Ilfracombe ..	4 Market Street	758	Minor Ailment	5		
	,, ,, ...		Vision			½
	,, ,, ...		Dental (part-time) ..	3		
	,, ,, ...		Speech	1		
Ivybridge ..	Methodist Sunday School Room		Minor Ailment		1	
	,, ,, ...		Speech	1		
Kingsbridge ..	Tresillian	2280	Minor Ailment	1		
	,, ...		Vision			
	,, ...		Dental (part-time) ..	3		
	,,		Speech	1		
	Co. Primary School ..	2009	Remedial Exercises ..	1		
Lifton.. ..	Methodist Church Rooms		Minor Ailment			1
Lynton ..	Jubilee Hall		Minor Ailment		1	
Morchard Bishop ..	Memorial Hall		Minor Ailment			1
Moreton-hampstead	C.P. School		Speech	1		
Newton Abbot	Glencoe, Courtenay Park	377	Vision		1	
	,, ,, ,,		Speech	2		
	,, ,, ,,		Dental (whole-time) ..		21	
Newton Abbot	Highweek C.P.		Speech			4
Northam ..	Church Hall		Minor Ailment		1	
Okehampton..	Fairplace Methodist Rooms		Minor Ailment		1	
	,, ,, ,,		Vision			1
	,, ,, ,,		Speech	1		
Paignton ..	Central Clinic, Midvale Rd.	59131	Consultation		1	
	,, ,, ,,		Vision			2
	,, ,, ,,		Dental (part-time) ..	6		
	,, ,, ,,		Speech	2		
Plympton ..	The Clinic ..		Minor Ailment ..	1		
	Station Road ..	2527	Speech	1		
	,, ,,		Vision			1
	,, ,, ...		Dental (part-time) ..		1	
Plymstock ..	Horn Cross Lane	42677	Minor Ailment	1		
	,,		Vision			
	,, ,, ,,		Dental (part-time) ..	5		
	,, ,, ,,		Speech	1		
	,, ,, ,,		Remedial & Breathing Exercises	1		
Roborough	Recreation Hut ..		Minor Ailment ..			
	Maristow Sp. School ..		Speech	1		
Seaton ..	Women's Institute ..		Minor Ailment ..		1	
Sidmouth ..	St. Nicholas School ..		Minor Ailment .. .	1		
	,, ,, ..		Vision			½
	Woolbrook S.M. ..		Minor Ailment	1		
	,, ,, ..		Dental		1	
	Manstone Ave. School		Speech	1		
Sticklepath	Church Hall		Minor Ailment ..			1

Town	Address	Phone No.	Type of Clinic	½-day Sessions: Week	Fortnight	Month
South Molton	99 East Street		Minor Ailment		1	
	,, ,,		Speech		1	
	,, ,,		Vision			½
	,, ,,		Dental (part-time)	2		
Tavistock	Crowndale Road		Minor Ailment			4
	,, ,, ,,		Vision			1
	,, ,, ,,		Speech	1		
	,, ,, ,,		Dental	1		
Tiverton	St. Andrew Street	2708	Minor Ailment	1		
	,, ,,		Dental (part-time)	5		
	,, ,,		Speech	2		
	,, ,,		Vision			½
	,, ,,		Orthodontics	1		
Torquay	Castle Road Clinic	7963	Minor Ailment	5		
	,, ,, ,,		Speech	2		
	,, ,, ,,		Hearing Assess			1
	,, ,, ,,		Dental (whole-time)	15		
	,, ,, ,,		Vision	1		
	,, ,, ,,		Child Guidance	4		
	Barton Clinic	87274	Minor Ailment	5		
	,, ,,		Dental (whole-time)		21	
	,, ,,		Speech	1		
	West Hill School	87090	Minor Ailment	5		
	Torbay Hospital		Hearing Assess			1
	Pitt House Senior		Speech	1		
	Steps Cross School		,,	1		
Torrington	Church House, New Street		Minor Ailment	1		
	,, ,, ,,		Speech	1		
	Secondary Modern School	2186	Vision			½
Totnes	Borough Park	2078	Dental (part-time)	4		
	Secondary Modern School	2392	Vision			1
	Borough Park		Speech	1		
Willand	Bradfield Sp. School		Speech	1		
Woolacombe	Methodist Hall		Minor Ailment		1	
Yealmpton	Chapel Rooms		Minor Ailment			1

The Minor Ailment Sessions include facilities for Diphtheria Immunization as required.

TABLE XVI

CAUSES OF DEATH AT DIFFERENT PERIODS OF LIFE IN THE ADMINISTRATIVE COUNTY OF DEVON 1962

Causes of Death	*Sex*	1962								
		All ages	0—	1—	5—	15—	25—	45—	65—	75—
All Causes	M.	3776	59	11	18	36	88	839	1123	1602
	F.	4178	68	16	10	15	94	625	899	2451
1. Tuberculosis—Respiratory	M.	17	—	—	—	—	1	9	6	1
	F.	7	—	—	—	—	1	2	2	2
2. Tuberculosis—Other	M.	1	—	—	—	—	—	—	1	—
	F.	1	—	—	—	—	—	—	1	—
3. Syphilitic Disease	M.	4	—	—	—	—	—	2	—	2
	F.	2	—	—	—	—	—	—	1	1
4. Diphtheria	M.	—	—	—	—	—	—	—	—	—
	F.	—	—	—	—	—	—	—	—	—
5. Whooping Cough	M.	—	—	—	—	—	—	—	—	—
	F.	1	1	—	—	—	—	—	—	—
6. Meningoccal Infections	M.	—	—	—	—	—	—	—	—	—
	F.	—	—	—	—	—	—	—	—	—
7. Acute Poliomyetis	M.	—	—	—	—	—	—	—	—	—
	F.	—	—	—	—	—	—	—	—	—
8. Measles	M.	—	—	—	—	—	—	—	—	—
	F.	—	—	—	—	—	—	—	—	—
9. Other Infective and Parasitic Diseases	M.	9	2	—	1	—	2	3	—	1
	F.	10	—	—	1	—	3	2	3	1
10. Malignant Neoplasm—Stomach	M.	103	—	—	—	—	1	33	42	27
	F.	85	—	—	—	—	1	17	18	49
11. Malignant Neoplasm, Lung, Bronchus	M.	205	—	—	—	—	3	97	73	32
	F.	53	—	—	—	—	2	17	24	10
12. Malignant Neoplasm, Breast	M.	1	—	—	—	—	—	1	—	—
	F.	139	—	—	—	—	8	56	36	39
13. Malignant Neoplasm, Uterus	M.	—								
	F.	59	—	—	—	—	9	23	16	11
14. Other Malignant and Lymphatic Neoplasms	M.	383	—	—	2	3	5	106	124	143
	F.	353	—	1	—	3	12	107	91	139
15. Leukemia, Aleukemia	M.	28	—	—	2	1	2	6	12	5
	F.	20	—	—	—	1	3	8	3	5
16. Diabetes	M.	12	—	—	—	—	—	2	5	5
	F.	36	—	1	—	—	2	4	16	13
17. Vascular Lesions of Nervous System	M.	487	1	—	—	1	4	78	133	270
	F.	828	—	—	—	—	6	103	183	536
18 Coronary Disease, Angina	M.	806	—	—	—	—	17	227	300	262
	F.	586	—	—	—	—	2	91	175	318
19. Hypertension with Heart Disease	M.	52	—	—	—	—	1	6	19	26
	F.	105	—	—	—	—	—	6	26	73
20. Other Heart Disease	M.	534	—	—	—	1	1	55	124	353
	F.	745	1	—	—	—	5	36	99	604
21. Other Circulatory Disease	M.	165	—	—	—	—	4	27	36	98
	F.	214	—	—	—	1	2	14	45	152
22. Influenza	M.	14	—	—	—	—	—	2	7	5
	F.	10	—	—	—	—	—	1	3	6
23. Pneumonia	M.	165	7	4	—	1	1	17	49	86
	F.	187	9	3	1	—	1	13	33	127
24. Bronchitis	M.	208	—	—	2	—	1	54	67	84
	F.	84	1	—	1	—	1	7	21	53
25. Other Diseases of Respiratory System	M.	47	—	—	—	1	—	14	12	20
	F.	23	—	—	—	1	1	4	7	10
26. Ulcer of Stomach and Duodenum	M.	34	—	—	—	—	2	7	14	11
	F.	24	—	—	—	—	—	5	7	12
27. Gastritis, Enteritis and Diarrhoea	M.	10	1	1	—	—	—	1	2	5
	F.	17	—	3	—	—	—	1	5	8
28. Nephritis and Nephrosis	M.	23	—	—	1	—	1	8	7	6
	F.	27	—	—	—	—	1	5	7	14
29. Hyperplasia of Prostate	M.	58	—	—	—	—	—	2	18	38
30. Pregnancy, Child Birth, Abortion	F.	2	—	—	—	—	2	—	—	—
31. Congenital Malformations	M.	22	14	1	1	—	5	1	—	—
	F.	39	23	3	2	—	3	7	1	—
32. Other Defined and Ill-Defined Diseases	M.	214	31	1	2	—	8	35	49	88
	F.	375	28	1	1	6	15	68	60	196
33. Motor Vehicle Accidents	M.	38	—	1	3	19	4	5	4	2
	F.	18	—	3	1	2	2	4	2	4
34. All Other Accidents	M.	79	3	3	3	6	11	20	9	24
	F.	96	5	—	1	1	5	9	10	65
35. Suicide	M.	52	—	—	—	3	11	20	10	8
	F.	27	—	—	—	—	7	13	4	3
36. Homicide	M.	5	—	—	1	—	3	1	—	—
	F.	5	—	1	2	—	—	2	—	—

Table XVII. STATISTICS—COUNTY OF DEVON—1962

Area	Districts		Population (Est. Mid 1961 Home)	Births Rates per 1,000 Population			Infant Deaths		Tuberculosis and Other Infectious Diseases	Cancer and Other Malignant Diseases	Vascular Lesions of Nervous System	Heart and Circulatory System	Respiratory (excluding Tuberculosis)	Stomach and Digestive System	Genito-Urinary	Maternal	All Others	Accident Suicide Etc.	Total Deaths		
				No.	Crude Rate	Corr't'd Rate	Under 1 year No.	Under 4 weeks No.	1—9	10—15	17	18—21	22—25	26—27	28—29	30	16, 31, 32	33—36	No.	Crude Rate	Carr't'd Rate
1	Exmouth	U.D.	19,890	304	15.28	16.66	5	5	4	68	67	131	28	3	3	—	38	8	350	17.60	12.67
	Budleigh Salterton	U.D.	3,720	40	10.75	14.73	—	—	2	11	12	24	6	3	2	—	4	2	66	17.74	9.76
	St. Thomas	R.D.	35,940	566	15.75	18 11	13	12	9	80	64	185	55	4	10	—	36	28	471	13.11	9.70
2	Honiton	M.B.	4,550	67	14.73	19.74	2	1	—	5	16	29	6	—	—	—	9	5	70	15.38	10.46
	Ottery St. Mary	U.D.	4,080	56	13.73	14.28	—	—	—	15	11	23	6	1	—	—	6	4	66	16.18	12.94
	Sidmouth	U.D.	10,220	99	9.69	12.79	3	3	—	48	34	83	16	1	4	—	14	9	209	20.45	11.25
	Seaton	U.D.	3,360	33	9.82	10.70	—	—	—	16	16	26	7	2	—	—	3	6	76	22.62	14.02
	Axminster	R.D.	14,510	181	12.47	14.34	1	1	—	44	41	63	12	2	5	—	8	4	179	12.34	9.87
	Honiton	R.D.	6,970	107	15.35	17.19	4	4	—	17	14	29	4	—	—	—	15	5	84	12.05	11.33
3	Tiverton	M.B.	12,770	246	19.26	19.07	4	2	3	22	31	60	32	—	—	1	10	4	163	12.76	10.72
	Crediton	U.D.	4,420	57	12.90	12.38	1	1	1	21	11	25	12	—	1	—	5	2	78	17.65	14.12
	Crediton	R.D.	9,710	166	17.10	19.32	4	3	2	17	15	44	10	1	1	—	6	8	104	10.71	9.85
	Tiverton	R.D.	20,660	332	16.07	17.52	6	3	2	44	42	88	31	3	2	—	20	12	244	11.81	10.63
4	Barnstaple	M.B.	15,650	289	18.47	19.02	3	3	4	47	27	100	20	3	4	—	20	3	228	14.57	11.80
	South Molton	M.B.	2,950	40	13.56	14.78	2	1	1	8	7	30	16	1	1	—	8	3	75	25.42	18.81
	Ilfracombe	U.D.	8,510	102	11.99	13.67	2	2	1	33	17	58	14	1	4	—	10	7	145	17.04	12.44
	Lynton	U.D.	1,700	21	12 35	12.47	—	—	—	2	6	12	4	1	—	—	4	1	30	17.65	13.41
	Barnstaple	R.D.	25,580	353	13.80	15.04	6	4	1	74	61	133	22	2	7	—	25	11	336	13.14	12.09
	South Molton	R.D.	8,400	135	16.07	18.48	3	3	—	15	15	39	6	3	1	—	8	6	93	11.07	10.30
5	Bideford	M.B.	10,820	161	15.88	16.67	2	2	—	29	17	67	8	3	2	—	7	5	138	12.75	9.95
	Gt. Torrington	M.B.	2,880	39	13.54	15.30	1	—	—	10	13	21	9	1	—	—	3	2	59	20.49	14.14
	Holsworthy	U.D.	1,580	15	9.49	9.11	—	—	—	1	3	12	4	—	—	—	2	—	22	13.92	10.16
	Northam	U.D.	6,530	84	12.86	14.15	1	1	1	25	16	45	10	6	1	—	4	1	109	16.69	12.85
	Bideford	R.D.	4,800	75	15.62	19.21	1	1	—	12	10	22	2	1	2	—	2	3	54	11.25	9.11
	Torrington	R.D.	7,190	97	13.49	15.92	4	3	—	10	13	39	8	—	4	—	12	5	91	12.66	11.27
	Holsworthy	R.D.	5,780	88	15.22	17.05	1	—	—	8	11	37	8	1	1	—	7	2	75	12.98	11.42
6	Okehampton	M.B.	3,800	46	12.11	12.84	—	—	1	18	14	24	14	2	—	—	5	3	81	21.32	15.35
	Tavistock	U.D.	6,310	82	13.00	14.95	2	1	—	12	16	45	5	—	1	—	5	3	87	13.79	9.65
	Broadwoodwidger	R.D.	2,020	27	13.37	14.04	—	—	—	3	1	8	—	—	—	—	—	—	12	5.94	7.01
	Okehampton	R.D.	11,270	185	16.42	19.38	2	1	1	30	30	61	17	5	3	—	18	8	173	15.35	12.74
	Tavistock	R.D.	15,250	261	17.11	20.87	2	—	—	36	29	101	17	1	5	—	14	9	212	13.50	12.23
7	Kingsbridge	U.D.	3,210	42	13.08	14.13	1	1	1	9	5	12	7	2	3	—	6	2	47	14.64	12.74
	Salcombe	U.D.	2,370	22	9.28	11.14	—	—	—	12	4	13	8	—	—	—	1	1	39	16.46	11.19
	Kingsbridge	R.D.	11,350	171	15.07	17.33	6	5	1	28	23	54	17	3	—	—	14	8	148	13.04	10.95
	Plympton St. Mary	R.D.	40,450	775	19.16	19.93	12	9	—	71	67	196	39	4	12	—	48	19	456	11.27	11.38
8	Dawlish	U.D.	7,530	83	11.02	13.11	—	—	—	19	24	46	7	1	2	—	15	2	116	15.41	11.40
	Newton Abbot	U.D.	18,080	297	16.43	16.76	5	4	—	46	46	121	31	2	1	1	35	9	292	16.15	11.63
	Teignmouth	U.D.	11,230	116	10.33	12.29	—	—	2	30	36	84	15	—	3	—	23	9	202	17.99	10.97
	Newton Abbot	R.D.	26,280	354	13.47	15.63	6	3	3	73	55	161	26	6	4	—	30	18	376	14.31	11.73
9	Torquay	M.B.	51,700	621	12.01	13.21	10	3	7	144	159	374	86	6	4	—	63	35	878	16.98	11.89
10	Totnes	M.B.	5,880	72	12.24	12.97	1	—	—	18	13	27	5	1	1	—	20	5	90	15.31	10.41
	Ashburton	U.D.	2,720	38	13.97	15.09	—	—	—	8	14	19	3	1	—	—	5	1	51	18.75	13.13
	Buckfastleigh	U.D.	2,520	29	11.51	13.47	—	—	1	6	3	22	4	—	—	—	2	1	39	15.48	11.92
	Totnes	R.D.	14,310	196	13.70	16.44	1	1	1	46	57	99	21	3	3	—	28	9	267	18.66	11.57
11	Dartmouth	M.B.	6,360	81	12.74	13.89	2	1	—	20	13	24	12	—	1	—	10	6	86	13.52	11.76
	Brixham	U.D.	10,870	167	15.36	15.36	2	1	1	23	27	67	13	—	2	—	31	4	168	15.46	13.91
	Paignton	U.D.	29,810	368	12.34	13.45	6	5	2	95	89	224	35	5	8	—	39	22	519	17.41	12.71
	Administrative County		536,490	7,786	14.51	15.96	127	90	52	1,429	1,315	3,207	738	85	108	2	698	320	7,954	14.83	10.83